Addiction and Lifestyles in Contemporary Europe: Reframing Addictions Project (ALICE RAP)

Stakeholder ownership: a theoretical framework for cross national understanding and analyses of stakeholder involvement in issues of substance use, problem use and addiction

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Abstract

This project contributes to understanding of the role of different stakeholder groups in the formulation and implementation of policy in the addictions field in Austria, Denmark, Finland, Italy, Poland and the UK. It comprises a number of case studies which draw on a range of theoretical frameworks to examine stakeholder dynamics at international, national and local levels. Mainly qualitative methods were used: interviews, policy and documentation analyses, webcrawler network analysis, and simple surveys; one case study was based on a survey only. The case studies fall into four main categories: three focus on controversial issues in drug treatment policy and practice – opioid substitution treatment, drug consumption rooms, and heroin assisted treatment; three look at stakeholder activity in alcohol control and public health; one pilot case study considers the potential role of researchers in the development of a scientific network around gambling; and one looks at the role of nurses in implementing brief interventions. In addition, themes explored across case studies included the role of evidence and stakeholder activity, drug users as stakeholders, and the role of external stakeholders on national policy. Professional stakeholders at implementation level and families and drug users as stakeholders are also considered. The case studies revealed that, in many instances, the addictions field is characterised by tensions between groups, by entrenched relationships between some addiction-specific stakeholder groups and powerful political stakeholders, and by the dominance of some forms of evidence over other forms of knowledge. Science and scientists are only influential in policy terms if their scientific findings 'fit' with the wider political context. Nevertheless, at least within the European context, there are opportunities for new stakeholder groups to emerge and gain policy salience and there are opportunities for stakeholders to challenge prevailing frames of understanding the addictions and prevailing modes of responding to problems of substance misuse and addiction.

1. Introduction

1.1.Change and growth of stakeholder groups

Policies to address issues of substance use, problem use and addiction have varied greatly across time and geographical location. Shifts in policy approaches have come about as the 'problem' has been defined, framed and re-framed thereby altering understanding of the issues and the necessary response. Political imperatives, social and economic pressures and cultural changes have also influenced when, how and who uses any particular substance and the 'rules' concerning acceptable and non-acceptable behaviours. Thus, the social actors and groups – or stakeholders - concerned with issues of substance use and addiction and with policies to manage the production, distribution and use of addictive substances have changed and, in the contemporary period, have grown in number and diversity. Today, the concept of addiction has spread beyond substance use to include a range of behaviours, excessive use of mobile phones or television, excessive shopping or sexual activity, gambling, work and 'junk' food. Along with lifestyle and behaviour change comes a panoply of actors – those who become addicted, those who produce or distribute addictive substances, those who wish to prevent or treat the problem, and so on. Even restricting our view to European and other 'western' societies, religious groups and institutions, philanthropists, medical professionals, psychologists and social care workers, specialist treatment workers and treatment communities, criminal justice workers, trade and industry groups, researchers, the media, a range of government departments and civil authorities, and substance users, themselves, are among the many individuals and groups which can affect, or may be affected by, drug and alcohol policies. Alcohol and drug policy has relevance for major state institutions - economic, health, leisure and criminal justice institutions, for example, and they, too, may be considered stakeholders. In any country, the structures and processes of governance also have significance for the range and nature of stakeholder groups, institutions and authorities. As governance is devolved in many countries to regional, municipal and local levels, stakeholder groups and networks become relevant at different levels of policy formation and implementation although some groups or individuals are likely to span the different levels. As our Danish partners have commented, a shift from 'government' to 'governance' means

> "decentring policy and the focus of policy research away from the institutions of the state, formal decision making and implementation through public institutions and towards the enactment of governance via the negotiations between a multitude of public and private actors and institutions ….. While public institutions still play a role in governance, their authority is delegated and negotiated" (Houborg and Frank 2014).

At the same time, the growing importance of international agreements, regulations and epistemic or knowledge communities may exert external influence, and at times pressure, on national policy. On the other hand, as shown in another WP2 case study (Beccaria et al., in press) the authority of external stakeholders may be used by domestic actors to revise national policies or resist changes. Multi-level stakeholder structures are, therefore, a feature of the policy landscape. Consideration of multi-level interests is also a core aspect of stakeholder analyses. Examination of the relationship between stakeholder groups and policy on substance use and addiction inevitably entails consideration of power, influence and the dynamics of interaction between social actors striving to promote their preferred policy options. Indeed, frequently policy debate on alcohol and drug issues becomes "an arena for the struggle of controversial ethical and moral opinions and interests" (Eisenbach-Stangl, 2013). In this struggle, the production, use and dissemination of 'evidence' becomes an important tool and a

tactical strategy to gain legitimation and credibility for a particular rationality of action (Hellman 2012). Thus, as patterns of drug use change and as policy designed to address the problems of drug or alcohol use in turn influences new behaviour patterns, the composition and influence of stakeholders varies and changes. This brief overview indicates the complexity of stakeholder activity and illustrates the need to map out the stakeholders relevant to a specific policy issue and contextualise their activities within the different national cultures and the political, health and social systems in force at any particular time.

1.2. Study aims and objectives

As part of Area 1 'Ownership of Addictions', WP2 aimed to advance understanding of the processes and factors contributing to shifts in policy responses to the use of addictive substances and to addictive behaviours. In particular, this WP aimed: to further understanding of the roles of selected stakeholder groups in relation to alcohol and drug policy; to explore the interaction between stakeholder activity and other factors influencing the policy process; to demonstrate the use of different theoretical perspectives to contribute to analyses of stakeholding in drug and alcohol policy; and to provide a cross-national framework for stakeholder analyses.

The specific objectives were to:

- Provide an account of the emergence, rise and demise of different stakeholder groups in different social, economic, cultural and policy contexts across the six European countries collaborating in this WP.
- Examine evidence for the influence (power) of different stakeholder groups on policy and intervention approaches, on the consumption of different substances, and on the development of different responses to use/addiction.
- Analyse the factors associated with the positioning of different stakeholder groups within the policy arena in different national contexts and at the supranational level.
- Determine if or how multi-stakeholder dialogue is used to build consensus in arenas of contest on addictions policy.
- Develop a theoretical framework for cross-national analysis of stakeholder involvement in issues of use/ problem use/ addictions, and on the development of different responses to use/ addiction.

A series of case studies (discussed below) was the approach chosen to achieving the aims and objectives.

1.3. Conducting cross-national comparative research: Concepts, language, and meaning

Comparative research, which encompasses both quantitative and qualitative comparison of social entities, is regarded as an important and useful sociological approach. At the same time, conducting comparative cross-national research raises a host of issues and challenges that have been extensively discussed in the literature (e.g. Kohn, 1989, ed.; Livingstone 2003; Mills et al., 2006). Mills et al. (2006: 621) note 4 enduring methodological problems: case selection (unit, level and scale of analysis); variable or case orientation; issues of causality; and construct equivalence. The first three are taken up in the methods section below. The issue of construct equivalence, discussed here, draws attention to the need for comparative research to consider the definitions and measures used to investigate the phenomenon and the extent to which there is construct equivalence across all countries involved in the research. Discussing large-scale cross-national, comparative survey work, Jowell (1998) pointed to language and idiom as

an important factor that can bias or distort research findings. Specifically, does our key concept, 'stakeholder', mean the same and have the same significance in all partner countries? How do researchers translate the concept into their own language for research purposes and does the translation import subtle differences of meaning? WP2 partners considered the questions - Is there a word in your own language for 'stakeholder'? If not, do you use the English word when you write in your own language or do you use 'interest group' or some other concept? If you use something else, what word(s) do you use? The following replies were given:

Austria: There is no translation of stakeholder. Stakeholder is a rarely used term in social sciences and if it is used it is mainly used within a special theoretical context, that is within systems theory. The term mainly used is interest group: interest and interest groups are terms with a great history and tradition in German sociology and political science (contrary to stakeholder) and they have a societal critical (gesellschaftskritische) and economy critical connotation. The term stakeholder is perceived as a suitable description for societies with a strong economy and a weak state, whereas the term interest group corresponds to societies with a strong state - a formation prevailing in Continental Europe. I am only talking about terms used in social sciences; neither term belongs in everyday language.

Denmark: In Danish 'stakeholder' and 'interessent' are used. 'Interessent' comes from 'interesse' (stake), and means a party with an interest in the case. While we have this Danish word for stakeholder, we often use the English word 'stakeholder'.

Finland: There is no such exact word, it is used in international /English discussions. In Finnish: the exact translation is 'osakas' or 'sidosryhmä' (the former more as shareholder in business, the later means 'interest group', and is used in organizational life), but in the policy field we speak often of companions 'kumppani', or companionship 'kumppanuus' (a mode of involving interest parts that started to figure especially in the beginning of the 2000s). Organizations that are in a companionship are referred to as 'järjestökumppani' (järjestö= organization, kumppani= companion) or 'järjestökumppanit' (in plural). Other possible words are 'tekijä' (subject, factor), 'partneri' (partner), or 'toimija' (actor).

Italy: The Italian translation of stakeholders is "portatori di interesse" (that is exactly interest group), but more and more the English word is used also in Italian language.

Poland: There is a new expression in Polish for a stakeholder "interesariusz" but it is quite an artificial linguistic invention. In professional conversation I would say "stakeholder" which would be understandable for most people working in social sciences. Sometimes we also use a concept "aktorzy spoleczni" - social actors instead. Currently, main stream debate in Poland avoids using terms and concepts associated with Marxism such as interest groups. And therefore, the concept of "interesariusz" was invented which sounds very artificial to my ears and suggests a hidden agenda. The previous ('Marxist') term was "grupa interesow" (singular) or more often "grupy interesow" (plural).

UK: In the UK, stakeholding as a concept became prominent within political and policy discourse in the 1990s and is particularly associated with 'Third Way' thinking as epitomised by New Labour in Great Britain. Among other things, it is linked to notions of decentralisation of power and the ideal of partnership, including the encouragement of public-private partnerships. The ideas were being discussed pre-1997 (election of New Labour) – Hutton (1995) spoke of stakeholder capitalism which included the need to create a new financial architecture in which private decisions produced a less degenerate capitalism.

These comments indicate that, although the English term 'stakeholder' is common usage especially in research or 'scientific' discourse, there are other terms in use. Some terms (including 'stakeholder') have political or economic significance and are linked to particular political or economic ideologies; some, such as the Finnish words, convey a relationship status, e.g. 'partneri', which might imply a more consensual relationship than some of the other terms.

In researching stakeholder groups, which word is used – or used to explain 'stakeholder' - may depend on factors such as the context of the interview or on the background and experience of the interviewee. Questions of language and translation of ideas as well as words are acknowledged as important; but, it was not possible to explore all the concepts we used in detail. However, although taking a pragmatic approach to the language issues, the key concept of 'stakeholder' warranted attention and WP2 partners considered how 'stakeholder' and 'interest group' had been defined and discussed in the literature.

1.3.1 'Stakeholder' and 'interest group': definitions and theories

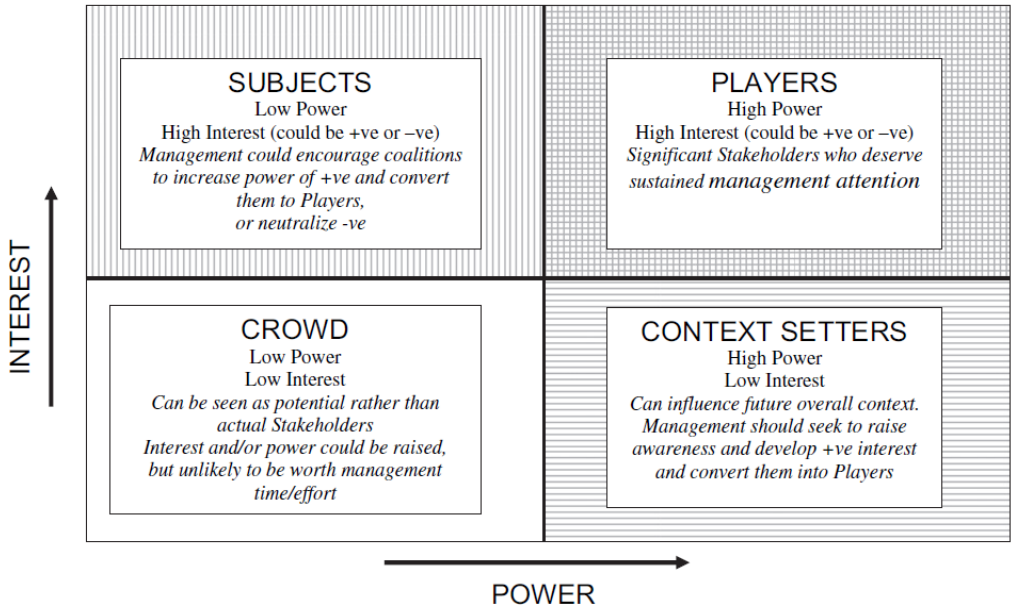
The concept of 'stakeholder' and the initial development of stakeholder theory is rooted in the business science literature (Clarkson, 1995; Freeman, 1984), but has become prominent within political and policy discourse since the 1990s. The concept has generated much debate and has been criticised as vague and ambiguous (Fassin, 2009). There is no common consensus as to what the concept of stakeholder means, with hundreds of definitions published (Wagner Mainardes et al., 2011; Miles, 2012). Who 'counts' as a stakeholder differs significantly depending on whether a narrow or broad definition is used. Those adopting a narrow definition have tended to emphasise the legitimacy of stakeholder claims, whereas those preferring broad definitions have stressed the stakeholder's power to influence an organisation regardless of legitimacy (Mitchell et al., 1997). A key distinction in the conceptualization of stakeholders is the distinction between stakeholders that *affect* a policy or an organization and stakeholders that are *affected.* The two are not mutually exclusive, but neither are they necessarily connected. Stakeholders may thus be affected by a policy without being able to affect it. This, of course, concerns issues of *power* and its distribution among stakeholders. A number of writers have addressed this issue and insights from their work informed WP2 case studies.

Mitchell *et al* (1997) argued that all stakeholders possess some kind of combination of three critical attributes: *power*, *legitimacy* and *urgency*. *Stakeholder salience*, that is "the degree to which managers give priority to competing stakeholder claims" (Mitchell et al., 1997: 869) is viewed as positively related to the accumulative number of the three attributes of power, legitimacy and urgency. Legitimacy and urgency tend to be dynamic rather than static; they are socially constructed and determined by perception rather than by objective reality; and stakeholders holding one or more of the three attributes may not be aware of them or may choose not to use them.

The power/interest matrix as presented by Akermann and Eden (2011) (see figure 1) is also relevant when translating stakeholder theory from business and management literature into the social sciences as this helps us distinguish between different stakeholders according to their power and their 'stake' in the issue at hand. Ackermann and Eden's matrix consists of four compartments based on the strength of stakeholders' power to influence the future of an issue and on the degree of interest stakeholders have in the issue. In this way some stakeholders may be powerful and have a strong interest in the issue; these stakeholders are defined as *players.* Other stakeholders may be powerful, but have a weak interest in the issue;

these stakeholders are defined as *context setters.* Yet other stakeholders may be less powerful, but have a strong interest in the issue; these are defined as *subjects.* Finally, some stakeholders may be less powerful and have a weak interest in the issue; they are defined as *crowd.* In terms of the definition of stakeholders as actors that affect or are affected by a policy this matrix helps us distinguish between stakeholders according to their power to affect the policy and the degree of their interest in relation to how they are affected. As Hellman (2012) discusses, current trends in the addictions field, especially in relation to alcohol, towards a multi-stakeholder approach to policy-making, highlight the importance of considering inequalities in the power position of different stakeholder groups. Multi-stakeholder approaches, she argues, require the incorporation of different rationalities, different understandings of the issues, and different beliefs about solutions, into a consensus model of action which fails to take account of unequal political power.

Figure 1: Power/interest matrix



(Reprinted from Ackerman & Eden, 2011: 183)

Ackerman & Eden (2011) use the term 'interest groups' stressing the question of power and interests while 'stakeholders' suggests efforts to get consensus across varying interests. Nevertheless, the concept of interest group, itself, has different meanings. Beyers, Eising & Maloney (2008) define interest groups according to three factors: organisation, political interests and informality. Interest groups are thus organised forms of political behaviour that seek to influence policy, but without seeking political office. The authors distinguish between interest groups that are formed with the purpose of influencing policy, such as Greenpeace, and 'latent interest groups' such as sports clubs, that would normally not seek to influence policy, but may do so under particular circumstances. This definition of interest groups involves collective action of some kind undertaken in order to influence policy. Interest groups have been classified in other ways under a variety of labels; for instance, groups may be classified according to their function into partial or sectional groups where the main goal is to protect the interests of members (e.g. trades organisations and professional associations) and into cause groups, interested in promoting a specific issue or cause (e.g. drug user rights, drug decriminalisation). Walt (1994) discusses a further distinction between 'insider' groups – recognised and legitimised by government (e.g. Association of British Pharmaceutical Industry)

– and 'outsider' groups, those which do not enjoy the same level of legitimacy and may find it difficult to penetrate the policy process (e.g. drug user groups). This way of classifying groups rests on their relationship to decision-making authorities and their power to influence such authorities.

Considering these definitions, both 'interests' and 'stakes' may be defined in relation to structural and other (individual) characteristics as well as to subjective opinions and attitudes. In addition, stakeholders and interest groups are not necessarily actively engaged in political behaviour. The latter point is important because there may be actors who are affected by a policy or an issue, but who cannot, will not, or do not contemplate engagement in political behaviour in order to influence policy. Alcoholics Anonymous and Narcotics Anonymous, for instance, are two such groups. Thus, what constitutes a stakeholder will always be an empirical question which demands investigation of how different actors affect and/or are affected by a policy. (See: Houborg et al., in press, for a fuller discussion of the stakeholder concept). For the purposes of this research, partners agreed to use the term 'stakeholder' and to adopt the broad definition suggested by Brugha and Varasovsky (2000: 341). They define 'stakeholder' as:

> "… actors who have an interest in the issue under consideration, who are affected by the issue, or who – because of their position – have or should have an active or passive influence on the decision-making and implementation processes."

Thus, theoretical insights from both the literature on stakeholders and on interest groups, confirmed the importance of considering a number of key factors in each country, in particular issues of power and influence, insider and outsider status, legitimacy and policy salience, the interplay between power and interest and the mechanisms (tactics) stakeholder groups employed to gain or retain policy salience. These issues might be formulated as the 'starter' theoretical propositions for WP2:

- Stakeholder activity has the potential to influence policy.
- Policy can influence stakeholder power and position.
- Stakeholders gain policy salience by acquiring power, legitimacy and urgency.
- Stakeholders employ a range of tactics in attempts to gain policy saliency.
- Stakeholder position in a policy arena is partly dependent on power and interest (visible and invisible stakeholders; subjects, players, crowd, context setters).
- Stakeholder position can shift (towards greater or lesser policy salience) over time.
- Stakeholders are only one of multiple sources of influence on policy.
- Understanding wider political, economic, social and cultural contexts is important in investigating stakeholder salience.

Key questions, then, are: How, why and under what conditions do (some) stakeholders influence policy and how, why and under what conditions, do changes in stakeholder policy salience occur?

1.4. A case study approach

A number of reasons prompted the decision to adopt a case study approach. In particular, as a group of largely qualitative researchers in social science disciplines, the partners were most interested in furthering understanding of stakeholder activity as a complex phenomenon and situating it within an historical and contextualised 'real life' framework (Yin, 2009; Crowe et al., 2011). Adopting Miles and Huberman's (1994) definition of a case as "a phenomenon of some sort occurring in a bounded context", there were many options for a study design to investigate stakeholder activity in the addictions. We followed an interpretivist, constructivist approach as the aim was to understand individual and shared social meanings and to allow

participants to describe their version of events and the factors influencing outcomes in their own words (Searle, 1995; Stake, 1995). Stake (1995) characterises case studies as 'intrinsic' (where the case itself is the main interest), 'instrumental' (where the case study is used to gain insight into a specific issue or phenomenon) and 'collective' (where there are multiple case studies, conducted simultaneously or sequentially, which aim to replicate or compare findings across studies). Although not conforming entirely to Stake's 'instrumental' and 'collective' categories, WP2 carried out a series of case studies, some of which were designed to facilitate a high degree of comparability across countries and others which explored insights and specific aspects of stakeholder activity within different contexts and for different substances; each case study was, however, a single study complete in itself. (For further discussion of qualitative case studies see Hyett et al., 2014). Typically, case studies use multiple sources of evidence and may benefit from the prior development of theoretical propositions (as detailed above). As discussed later in section 3, WP2 partners used interviews, documentary sources and network mapping as the main data collection methods and within that, attempted to view stakeholder activity from a number of different perspectives. A more detailed account of the case studies and case study methods is given in section 3.

1.5. Structure of the report

In section 2, the main theories informing the design and analyses of the case studies are presented. Section 3, provides a detailed account of the case study methods. In section 4, main findings from the case studies are reported. The findings are presented under the following headings: stakeholder activity in drug treatment; stakeholder activity in alcohol control and public health; themes explored across case studies, comprising the role of evidence and stakeholder activity, professional stakeholders at implementation level, families and drug users as stakeholders, the role of external stakeholders on national policy. Conclusions are given in section 5 and here we include key findings and a framework for cross-national analyses of stakeholding in the addictions.

2. Theories informing the design and analyses of case studies

Table 1 lists the main theories informing each case study.

Table 1: List of main theories by case study

Case study	Theories
Substitution treatment (UK, MU)	Kingdon (1984, 1995); Backstrand (2003, 2004ª, 2004b)
Substitution treatment (Denmark, AU)	Kingdon (1984, 1995)
Substitution treatment (Italy, Eclectica)	Kingdon (1984, 1995); Gieryn (1983, 1999)
Substitution treatment (Austria, ECV)	Kingdon (1984, 1995)
Substitution treatment (Poland, IPiN)	Kingdon (1984, 1995)
Substitution treatment (Finland)	Boltanski and Thevenot (1991, 1999, 2006); Boltanski and Chiapello (2005)
Alcohol Health Alliance (UK, MU)	Sabatier (1998); Sabatier & Jenkins-Smith (1993, 1999); Sabatier & Weible (2007); Weible et al., 2009
Drug consumption rooms and the role of politics and governance in policy processes (Denmark, AU)	Kingdon (1984, 1995); Callon (1999); Callon et al (2002); Callon & Rabeharisioa (2002, 2008); Rhodes (1996)
The Italian politics of alcohol: the creation of a public arena at the end of the XXth century (Italy, Eclectica)	Wiener (1981)
Risky behaviour instead of temporary mental illness: A major change of alcohol policy in the 1950s in Austria and visible stakeholders (Austria, ECV)	Brugha and Varasovsky (2000); Varasovsky and Brugha (2000). Historical perspective
Changes in alcohol policy in Poland from its stakeholders perspective (Poland, IPiN)	Kingdon (1984, 1995); (Lenton 2006); Sabatier (1998); Sabatier & Jenkins-Smith (1993, 1999); Sabatier & Weible (2007)
Epistemic communities: A transnational knowledge network around heroin-assisted treatment (UK MU)	Gieryn (1983, 1999); Haas (1992, 2004); Stone (2002, 2003, 2012, 2013)
Epistemic communities (Denmark AU)	Cardillo et al. (2006); Glänzel & Schubert (2005); Granovetter (1973); Newman (2004)
Gambling: Researcher networks (UK MU)	
Sub-study: Feasibility of alcohol screening in emergency departments: a case study among nurses (Finland THL)	Empirical study

As well as examining the literature on the concept of 'stakeholder' and 'interest group', we began by looking at general theories on stakeholding and researching stakeholders (e.g. Brugha and Varasovsky, 2000; Varasovsky and Brugha, 2000). The review by Brugha and Varasovsky (2000) highlighted the varied policy roots of stakeholder analysis, which, as we

have seen above, draws on:

> "the earlier work of policy scientists who were concerned with the distribution of power and the role of interest groups in the decision-making and policy process." Stakeholder analysis, they argue, "focuses on the interrelations of groups and organisations and their impact on policy, within a broader political, economic and cultural context" (p240).

As noted in discussions of case study methodology (e.g. Miles and Huberman 1994), it is useful to develop the case study within a theoretical framework. Considering the broad historical-chronological approach needed to explicate shifts in policy and in stakeholder dynamics across time, Kingdon's (1984) classic study was chosen as a preliminary, overarching conceptual framework, as it provided a useful model for understanding policy formation and implementation as a process that is influenced by many diverse factors. Kingdon (1984) views the development of policy as the outcome of three sets of processes or "streams."

- The "problem stream" refers to which issues become recognized and defined as important or significant problems that require attention by policy-makers.

- The "policy stream" refers to the ideas or proposals for change developed by policy actors based on their knowledge and interest in particular issues.

- The "political stream" relates to the wider political environment that includes elections, swings in public opinion, ministerial changes, and interest groups' lobby.

At critical junctures, these three streams come together or merge and "policy windows" open, often very briefly, and shifts or transitions in policy can occur. Kingdon (1984:174) argues,

> "A problem is recognized, a solution is developed and available in the policy community, a political change makes the right time for policy change, and potential constraints are not severe."

Policy windows often open due to a pressing problem, such as the HIV epidemic or due to an event within the political stream such as an election. When these policy windows open, policy entrepreneurs can seize the opportunity to push alternative ideas and policy frameworks to tackle particular problems. Recognition of the putative condition as a problem may or may not be related to its 'objective', measurable spread. Thus, Kingdon's framework is useful in identifying the ways in which transitions in policy can occur and the conditions under which stakeholders can successfully negotiate a space for their ideas; it sheds light on how some policy ideas may emerge and flourish at particular points of time, while other policy options fade away; and, while allowing for the many influences on policy, it has regard to the role of 'policy entrepreneurs' in persuading key stakeholders to recognize problems and view them in terms of a particular perspective or ideological position (Kingdon, 1995). Use of Kingdon's policy streams and policy windows runs through most of the case studies carried out in WP2.

Within the overarching framework provided by Kingdon's (1994; 1995) theory, other theories were used to augment the conceptual framework and examine specific aspects of stakeholder activity, in particular, coalition and network formation, the strategies used to form and develop collaborative systems, and the tactics employed to gain policy salience.

Advocacy Coalition Framework (ACF) informed the examination of the conditions within which diverse stakeholder groups might collaborate around a specific policy issue. The ACF emphasises the importance of the policy subsystem, (defined by policy topic, geographic scope, and influencing actors) as the primary unit of analysis. Policy subsystem actors may include officials from all levels of government, scientists, consultants, professional groups, members of the media etc. Policies and programmes can be seen as translations of beliefs (or ideologies)

and according to ACF, belief systems underpin coalition formation (Sabatier and Jenkins-Smith, 1999). The ACF views the policy process as a competition between coalitions of actors who advocate beliefs about policy problems and solutions. Policy core beliefs have been described as the "glue" that binds members together to work on policy issues (Sobeck, 2003). The actors share a set of normative and causal beliefs and, through the management of any rival interests between stakeholder groups, engage in a degree of coordinated activity over time (Sabatier and Jenkins-Smith, 1993). Although a key element of the ACF is the distinction between policy subsystems and the broader political environment, there is an understanding that external events can impact on policy subsystems and that they operate within the wider political environment. The ACF prompted closer attention to the role of ideology in stakeholder activity and to the dynamics of stakeholder competition for legitimacy, power and policy salience. Insights from ACF underpinned the case study looking at the emergence and early development of the Alcohol Health Alliance (UK).

Examination of stakeholder networks and collaboration which crossed national boundaries began with considering epistemic community theories (in particular, Haas, 1992) but drew more substantially on Stone's concept of 'knowledge network' and Gieryn's theory of 'boundary-work'. Knowledge networks are concerned with "'codified' forms of knowledge produced by recognised intellectuals in the form of research and analysis" (Stone, 2003: 8). They are, therefore, sites of authority which emphasise a particular form of knowledge (Stone 2013). They create, exchange and transfer knowledge across national boundaries, can take different shapes over time and are not necessarily permanent entities. The expertise, scientific knowledge, professional experience and credentials of the actors in knowledge networks give them epistemic authority and credibility to inform policy and practice. Stone (2012) argues that influence rests in the aggregate contributions of wider networks of researchers who develop knowledge and evidence over time, rather than resting on individual contributions of lone scholars. Social practices in knowledge networks give their 'product' (i.e. ideas, publications and analyses), the illusion of scientific objectivity and technocratic neutrality. Participation in knowledge networks is restricted by boundary drawing (Gieryn, 1983) which excludes other forms of knowledge and expertise (e.g. experiential knowledge) which does not conform to techno-scientific criteria (Stone, 2003). Investigation of the knowledge network around heroin assisted treatment drew on work by Stone and Gieryn.

Following the social constructionist tradition of social problems, Weiner (1981) built on the work of earlier researchers who had examined the evolution of social problems from the definitional stage to the implementation stage to consider how the issue (in this case alcoholism) had been identified as a social problem warranting policy attention. She identified three main constituents of the collective definition of a social problem: *animating* the problem, *legitimizing* it and *demonstrating* it. *Animating* the problem includes understanding how participants (or stakeholders) establish turf rights (e.g., the growth of associations and the burgeoning of the research world around a specific issue), developing constituencies (e.g., the growth of an ideology of "citizen participation" and the distribution of funds), and funnelling advice and imparting skills and information (e.g., the expansion of training, schools, and courses imparting information and skills). The problem needs then to be *legitimized* by "borrowing prestige and expertise from other arenas", "lessening the attached stigma", "building respectability in the eyes of those outside the area", and differentiating alcohol problems from other (drug and mental health) problems (Wiener, 1981: 73). Finally, "constituents of the (alcohol use) arena have a *demonstrating* job to perform" (Weiner, 1981:156), a process that requires competing for attention, selecting supportive data, enlarging the bounds of respectability and convincing opposing ideologists. Wiener's conceptualisation of how a behaviour becomes identified as a problem, enters the public

arena and is taken up (or rejected) as a matter for policy intervention draws attention to the processes whereby stakeholders attempt to bring about policy change. This work informed the study of stakeholder influence on changes in Italian alcohol policy.

Turning to the strategies and legitimising activities of stakeholder groups, Boltanski and Thevenot's (1991; 1999; 2006) theory on justification proved insightful in considering the justifications put forward by different stakeholders in political and societal disputes. The theory underlines the process and negotiations behind decision-making, and focuses on ideas about "good life" and the question of who belongs in society as they appear in different justification "worlds". The theory on justification informed the examination of how stakeholders in Finland attempted to gain support for their view of opioid substitution treatment.

Theories on 'framing' also proved useful in thinking about how stakeholders went about the task of legitimising and demonstrating their vision of the nature of the problem and the appropriate policy option in an attempt to challenge dominant policy thinking and re-frame the issue in new ways. For example, work by Callon and colleagues (Callon 1998; 1999; Callon et al., 2002; Callon et al., 2009), based on the sociology of markets, illustrated how policy making involves a dynamic of continuous framing and overflowing. According to Callon collective action requires framing where certain aspects of reality, concerns and interests are defined as relevant for collective action while others are not. This could, for example, be whether or not to include practices of drug use and the perspectives of drug users as drug users in a policy directed at reducing drug related harm. This means that policy making continuously 'externalizes' or 'overflows' with concerns, interests, experiences and knowledge that are not taken into account. This in turn may, and often will be, the basis for certain stakeholders' attempts to get their concerns and interests taken into account through a reframing of policy. Furthermore because policy affects people in different ways, policy itself gives rise to new concerns, interests, perspectives and experiences and creates new stakeholders who may need to be accounted for. The concepts of framing and overflowing proved useful for illuminating a policy process concerning the introduction of drug consumption rooms in Denmark.

Scientific evidence is frequently advanced by stakeholders as the rationale (or justification) for preferred policy options. But the notion of what constitutes science is often contested especially in policy fields, such as drugs and alcohol, which are characterised by conflicting and sometimes hostile stakeholder groups and underpinned by divergent ideological stances. Gieryn (1983:781) addresses the problem of how to identify the unique and essential characteristics of science from other kinds of intellectual activity. He suggests that,

> "science can be made to look empirical or theoretical, pure or applied. However, selection of one or another description depends on which characteristics best achieve the demarcation in a way that justifies scientists' claims to authority or resources".

This process of constructing a boundary – 'boundary-work' – is important in the pursuit of professional goals and careers and a key strategy in stakeholder bids to position themselves favourably within the policy arena. Gieryn (1983) explains boundary-work as the process through which:

> "scientists construct ideologies with style and content well suited to the advancement or protection of their professional authority" (p.783).

As Gieryn (1999) contends, boundary work may further the *expansion* of authority or expertise or of jurisdictional control over a contested ontological domain. It may entail *expulsion* excluding rivals and defining them as outsiders with labels such as 'pseudo', 'deviant', or 'amateur'; boundary-work might then be a means of social control. Boundary- work may also

function as *protection of autonomy* when the aim is to exempt sciences (or members of a professional community) “from responsibility for consequences of their work by putting the blame on scapegoats from outside” (1983:792), for example, by “keeping science autonomous from controls by governments or industry” and by claiming “immunity from blame for undesirable consequences of *non-scientists*’ consumption of scientific knowledge” (p.789). However, more recent theoretical perspectives on the nature of evidence and evidence-based policy challenge notions of science and evidence and the traditional boundaries which define some forms of research based evidence produced by ‘experts’ as ‘science’ while other forms of evidence, for instance, practice based evidence or civic ‘science’ are granted lower status Bäckstrand 2003; 2004a; 2004b). Bäckstrand (2003; 2004a) argues that there is a constant re-evaluation of the status of expert knowledge and the boundaries between scientific and non-scientific knowledge, expert and lay knowledge, and global and local knowledge. Issues of evidence production, use and dissemination ran through many of the cases and are one of the cross themes discussed in the findings section (4.4.1).

3. Methods

3.1 Overview

It was recognised that using a case study approach meant we were working with a small number of units of analysis and considering many variables within each unit. However, it was not our intention to test or build causal models. Rather the intention was to reveal the combination of causally relevant conditions likely to facilitate understanding of complex interactions that might impact on policy issues within the drug and alcohol field. This approach also allowed us to site contemporary analyses within their historic contexts and explore how stakeholder dynamics had developed and changed over time (Ragin, 1987).

In all, including the sub-study, 13 case studies were undertaken by the partners. These were chosen to reflect relatively current issues in drug and alcohol policy where stakeholder activity had been visible or conflictual (e.g. drug substitution treatment, drug consumption rooms), to explore specific aspects of stakeholder dynamics (e.g. the formation of stakeholder alliances), to explore the interaction between policy change and stakeholder activity (e.g. trends in alcohol policy in different countries) and to consider the role of international epistemic communities or knowledge networks (e.g. researchers involved in heroin-assisted treatment). The emphasis was on the interaction between stakeholder groups and policy at national level although the issues around stakeholder differences and overlap at international, national and local level policy activity were acknowledged and discussed to some extent in the case studies. The sub-study took up stakeholder issues regarding one professional group, nurses, while other case studies focussed on the dynamics between different groups within the policy arena.

The first case study, carried out by the 5 partners in the core project, was on the same topic – opioid substitution treatment (Table 2, case studies 1-5). By chance, a colleague in Area 1 (Matilda Hellman) was working on a similar topic in Finland. A case study from that project was incorporated (Table 2, case study 6). These six studies on a common topic facilitated cross-national comparison and helped to identify commonalities and differences between countries in the factors influencing stakeholder activity and stakeholder salience.

Each partner was free to choose the topic of the second case study and each sought to explore one or more specific aspects of stakeholding (e.g. alliance formation, external influences on internal policy, initiation of new treatment systems: Table 1, case studies 7- 11). Both the 'epistemic community' study (Table 2, case study 12a, 12b) and the gambling case study (Table 2, case study 13) aimed to consider international knowledge networks, especially researcher networks, and their relevance to policy.

3.2. Case study methods

Apart from the sub-study, the research employed a range of qualitative methods to explore stakeholder dynamics and activities. This approach was chosen as most suitable for examining experiences and perceptions of stakeholder activity and its relevance to policy formation and implementation. It was also more likely than quantitative approaches to reveal cross-national differences, for example, beliefs about problem substance use and appropriate policy responses, or the importance of different factors in determining the emergence, survival and demise of different stakeholder groups. In-depth discussions, together with analyses of policy documents and other materials relevant to the specific policy issue and stakeholder group,

were chosen as suited to producing case study narratives. Table 2 provides an overview of the main methods used for each case study.

Table 2: Overview of case study methods

Case study	Interviews (number)	Stakeholder categories	Survey (yes/ no)	Other
1. Substitution treatment (UK, MU)	20	2 policy-makers, 6 representatives advocacy organizations, 5 representatives treatment sector, 5 researchers/scientists, 2 economic stakeholders	-	'Thick' description; Background documents / policy analysis
2. Substitution treatment (Denmark, AU)	17	2 civil servants, 8 treatment providers, 5 researchers, 2 NGOs	-	'Thick' description; Policy documents / research literature
3. Substitution treatment (Italy, Eclectica)	18	2 treatment providers, 2 presidents national TC organisations, 4 TC presidents, 3 presidents scientific societies, 2 clinical & epidemiological researchers, 1 pioneer of outpatient treatment, 1 head clinical unit, 2 representatives users' rights, 1 magistrate	-	'Thick' description
4. Substitution treatment (Austria, ECV)	13	2 drug researchers, 2 federal drug administrators, 1 regional drug administrator, 5 medical drug treatment professionals, 3 non medical drug treatment professionals		'Thick' description, legisltion analysis, literature review
5. Substitution treatment (Poland, IPiN)	18	4 policy makers/ politicians, 5 treatment providers, 5 NGO's, 3 researchers, 1 economic		'Thick' description; Legislation review
6. Substitution treatment (Finland)	15	Key informants from: 2 Ministry of Social Welfare and Health, 5 NGOs, 1 drug users' family organisations, 2 drug user organisations, 3 researchers, 2 public officials in municipalities		Analysis of media accounts
7. Alcohol Health Alliance (UK, MU)	9	1 civil servant, 3 medical doctors, 5 non-medical professionals from organisations members of AHA		Analysis of documents on AHA website
8. Drug consumption rooms and the role of politics and gov-ernance in policy processes (Denmark, AU)	21	1 medical doctor, 6 social workers, 4 police officers, 9 local residents, 1 bureaucrat	-	Thick description; Textual analysis different forms of recorded communication; Material relating to: the legislative process, to government policy, to local policy; Newspaper articles; Documents produced by NGO's.
9. The Italian politics of alcohol: the creation of a public arena at the end of the XXth century	14	2 university professors, 2 alcoholic beverage producers, 2 politicians, 1 civil servant, 1 representative scientific society, 4 treatment unit professionals, 2 self-help group representatives		Analysis 19 Parliamentary Bills

Case study	Interviews (number)	Stakeholder categories	Survey (yes/ no)	Other
(Italy, Eclectica)				
10. Risky behaviour instead of temporary mental illness: A major change of alcohol policy in the 1950s in Austria and visible stakeholders (Austria, ECV)	-	-		Documentary and policy analysis
11. Changes in alcohol policy in Poland from its stakeholders perspective (Poland, IPiN)	16	4 researchers, 4 policy makers/ politicians, 1 treatment professional, 3 AA abstainers clubs, 3 alcohol producers, 1 consumer organisation	-	'Thick description' Legislation review
12a) Epistemic communities: Exchanging, mobilizing and transferring 'expertise': the development of a transnational knowledge network around heroin-assisted treatment (UK MU)	11	9 scientists/researchers, 2 policy representatives	Yes*	Documentary analysis/ Mapping key experts
12b) Epistemic communities: web of influence (Denmark AU)	-	-	-	Webcrawler/ network mapping
13. Gambling (UK MU)	-	-	Yes+	Journal analysis/ key researcher analysis
Sub-study: Feasibility of alcohol screening in emergency departments: a case study among nurses (Finland THL)	-	-	Yes++	

* Short survey to the six EMCDDA Focal Point representatives in the countries that had trials and/or had implemented HAT

+ Short survey to request information from researchers working in gambling addiction

++ This was the main research method. It is described more fully below

As Table 2 shows, in-depth interviews formed the core of the empirical data collection. In most case studies, this was accompanied by policy analysis and the use of other relevant literature. Two small surveys were used predominantly to collect basic information and to identify respondents for interview or further contact. The journal analysis (gambling) used 2 of the foremost journals in the field to identify researchers and research institutions working in gambling addiction with a view to further contact. The webcrawler (epistemic community) was used to identify stakeholders through looking at citations in academic publications. This method maps specific research studies, research institutions and individual researchers, all of which may be considered to be 'stakeholders' and allows us to see interconnections. For the sub-study, data were collected using a questionnaire with structured and open-ended

questions assessing nurseś professional experiences and perceptions of the feasibility of using alcohol screening interventions in their daily work. The questionnaire was based on validated measures and comprised structured questions, each with two to four alternatives, and three open ended questions.

Recognising the importance of historical contexts as well as contemporary political, economic, social and cultural systems on issues of stakeholding, data collection for case studies 1-5 was preceded by the production of a background 'thick description' (Ponterotto, 2006) of the emergence and evolution of drug substitution treatment in each country. Along with insights emerging from the stakeholder literature, these descriptions helped to identify themes for exploration in the empirical work. Subsequent case studies, in a less formal, less structured way, also drew on a long-term perspective of how policy issues had developed and what had influenced the course of events. From the thick descriptions of drug substitution treatment, partners identified some common themes which cut across all these case studies and were mainly generalisable to later case studies:

- *Ideological tensions* between drug free/abstinence based regimes versus maintenance/harm reduction approaches (moral dimension).
- *The importance of 'crisis'* (eg. the impact of HIV/AIDS on prescribing policy) in all the case studies.
- *Tensions between the 'specialist' and the 'generalist'* in providing intervention.
- *Expansion and liberalization of controls* on prescribing over time. Moves towards more maintenance based treatment.
- *Tensions between the national, regional and local levels of responsibility* for substitute prescribing.
- *Changing role and influence of voluntary/statutory/private sector services*.
- *Influence from the scientific community/role of research*. Evidence base is similar across all the case studies, but the impact is different in each country.
- *Influence from the international community*, EU and EMCDDA.
- *Role of politics* in determining treatment options.
- *Economic dimension* of maintenance approaches vs drug-free/abstinence based models.

3.3 Sample selection, interview procedures and content, and data analyses

3.3.1 Stakeholder sample selection

Early discussions between partners considered drawing up categories of stakeholders with a view to selecting potential interviewees consistently across countries from each category. With the first case study, drug substitution treatment, this was envisaged as a possibility as all partners were investigating the same phenomenon. However, although it was easy to construct possible categories, even in the case of drug substitution treatment – where there were many similarities – we found that sampling had to be grounded in knowledge of the history and development of drug substitution treatment in each country, in knowledge of current stakeholder networks and in understanding of the specific country context. It was also impossible to draw distinct lines between stakeholder categories. For instance, clinicians who were 'treatment' stakeholders could also be researchers or part of a policy advocacy group. As a result, although guided by considerations of the need for cross-national comparability, each partner selected their own groups. An example from the Polish drug substitution treatment case study (Table 3) illustrates how partners grouped stakeholders as a basis for sample selection drawing on the 'thick' description of the history of drug substitution treatment in

their countries. The table also illustrates well a point made above – that there has been an expansion in stakeholder groups.

Table 3. Substitution treatment in Poland: ideology, organisation, stakeholders

Years	Ideology	Organisation	Legislation	Key stakeholders
1992	Poland – leader of change in Eastern Europe, enthusiasm about harm reduction measures in a context of epidemic of HIV infection among addicts, successfully curbed by combination of harm-reduction measures (syringe exchange, condom distribution) and education (routes of administration, counteracting anxiety). Openness for clinical innovations.	First methadone maintenance programme launched in the Institute of Psychiatry and Neurology (IPiN), Warsaw (about fifty clients).	Umbrella of a research project to test feasibility of methadone maintenance for people addicted from home made injectable opioid known as *kompot*. Programme introduced as high threshold treatment programme rather than expansion of harm reduction activities.	Scientists Clinical staff
1993 - 1995	Scientific evidence behind methadone maintenance as a high threshold approach.	Several more high threshold programmes, located in large urban centres (including two more in Warsaw) (several hundred clients all over the country).	No special legislation, methadone among legal medicines. Launching new programme needs positive opinion from IPiN, high threshold rules imposed.	Clinical staff Pharmaceutical company
1995	Insufficient treatment options available and disappointment with poor performance of existing treatment according to treatment experiences of addicts.	First maintenance programme in a smaller town - Starachowice launched within a drug prevention programme funded by the European Commission.	Formally the Starachowice programme as a branch of the IPiN programme.	Community action people Clinical staff Addicts as pressure group
1996-1999	High tide of conservative	A couple of new high threshold	Maintenance treatment	Clinical staff, NGO's running

Years	Ideology	Organisation	Legislation	Key stakeholders
	sentiments. Ideological clashes. Low threshold/harm reduction against high threshold/clinical approach. Maintenance against therapeutic community.	programmes (less than one thousand clients of 30 thousand heroin addicts).	anchored in the law on drug prevention; only distinct programmes, only public health sector eligible (1997).	therapeutic communities, State administration (National Bureau for Drug Prevention), Pharmaceutical industry
2000-2011	Ideological clashes continued. Conflicting economic interests. Buprenorphine as an option considered.	Despite few more programmes, including private ones, methadone maintenance still in short supply (around 15% of demand).	Provision for lower threshold approach. Non-public sector eligible to run maintenance programmes (2007).	Clinical staff NGO's running therapeutic communities State administration (National Bureau for Drug Prevention) Pharmaceutical industry National Health Fund Global Drug Policy Programme (Soros) National Drug Policy Network Media

A similar approach was taken to sampling across all case studies: initial mapping of relevant groups from policy documents, literature and the researchers' own knowledge of the field. Selection of interviewees to represent categories in as far as the categories were relevant to the topic of the case study and likely to add to the understanding of emerging themes. Snowballing was a feature of most case studies with interviewees suggesting other relevant stakeholders. The Italian partners for instance, described their study selection process as follows: "An initial list of Italian key SHs was developed through a preliminary research literature search of books, scientific articles, and grey literature. A snowball method was used to identify other key-informants (KIs) in the area of opioid dependence treatment until data saturation was reached (Glaser and Strauss, 1967) and interviewees began to suggest the same KIs who were already in the sample." (Beccaria and Rolando, 2014). In the case of the gambling case study, only a mapping was conducted.

3.3.2. Interview procedures and content

Similar interview procedures were followed in each country. Potential interviewees were approached by email or telephone with a request for interview. Information about the study was provided and consent agreed. In most cases interviews were recorded and transcribed. Interview time varied but was around 60-90 minutes in most cases.

For the five case studies on drug substitution treatment (Table 2, case studies 1-5), a working document set out a guide of five possible dimensions for investigation in the interviews:

- perceptions of the factors influencing policy development and policy change (e.g. new knowledge/research; changes in prevalence of opioid use/numbers in treatment; key events/reports/committees/meetings; 'crisis'; user benefits; cost/resources; influence from other countries; influence from other policy areas; political, economic and social changes; media influence)
- descriptions of, and perspectives on, the dynamics of stakeholder activity and the effects of activity on policy (map out main stakeholders; beliefs and ideologies; tensions; perceived influence of different groups
- perceptions of the impact of changes in policy on stakeholders' positions and influence (etc.) in the policy space/ arena (e.g. who benefits and in what ways, who is disadvantaged and in what ways; emergence of new stakeholder groups)
- perceptions of the dynamics between stakeholder groups and the factors which might influence their activities (e.g. alliances and consensus building between stakeholders, and activities directed towards 'legitimising' action and gaining policy salience)
- routes into influencing policy (e.g. alliances, communication, use of evidence, role of knowledge brokers)

Partners made flexible use of the guide and conducted interviews as open discussions giving interviewees plenty of opportunity to tell the story in their own way and so allow new themes and issues to emerge.

For subsequent case studies, partners constructed their own individual interview schedules but were guided to some extent by the emerging findings from the first case studies regarding important issues in stakeholder activity and the policy/ stakeholder relationship.

3.3.3. Analyses

As Varvasovszky and Brugha (2000: 338) note, a

> "key message is that the process of data collection and analysis needs to be iterative; the analyst needs to revise and deepen earlier levels of the analysis, as new data are obtained".

This was a guiding principle both within case studies and when planning second or subsequent case studies where findings from the first set of case studies informed the research questions and design of later ones. Case studies were analysed thematically (Miles et al., 2014; Miles and Huberman, 1994) and (apart from the sub-study) we did not attempt quantification of the data.

Especially for the drug substitution treatment case studies, themes and findings were discussed as the data was gathered and over the course of writing up the case studies for publication. The ideas emerging from the case studies were tested and presented at several international conferences and the feedback incorporated into further work. Specific themes were highlighted and elaborated. For instance, the first set of case studies on opioid substitution treatment indicated that the notion of evidence was contested and subject to constant revision as much due to changing political circumstances and stakeholder power and positioning as to new research findings. The concept of 'evidence' and its relevance to alcohol and drug policy was, therefore, further explored in a one-day conference and in a paper for publication (Duke and Thom, 2014). Two themes, drug users as stakeholders and the influence of external stakeholders on national policy, were the subject of further cross-national analyses in preparing chapters for a book (Bjerge et al., in press; Beccaria et al., in press). These cross-themes were developed through joint working with one partner from each contributing team participating in the analysis and writing. This way of working addressed the risk that the

influence of national contexts might be lost if analysis and interpretation is undertaken without input from someone with appropriate knowledge and understanding of the national situation (Jowell, 1998).
Although working in different languages – with all the issues that raises as mentioned earlier (section 1.3), the fact that national teams worked WP partners on case studies' designs and procedures and then discussed findings and interpretation of the data extensively across countries, went some way towards addressing difficulties raised by Jowell (1998); these included language and interpretation diversity, the need for findings to be located in an understanding of wider national contexts, acknowledging shortcoming which may be due to differences in conceptualising the issues, setting rules regarding 'technical standards' - research methods, procedures and analyses. Although we did not fully standardise methods and instruments, we aimed for consistency within a flexible framework.

Finally, there is some debate regarding whether cross-national research should focus on analysing the similarities between countries or the differences (Livingstone, 2003; Kohn 1998). In WP2, we looked at both, aiming to understand the processes and factors that resulted in similar or diverse policy outcomes in the topics we were investigating.

3.4. Ethical considerations

All partners conformed to the ethical regulations of their universities or organisations, seeking official ethical approval where this was standard practice. In most cases, interviewees were promised confidentiality and anonymity and this was respected in all published material. In one case study (Austria), it was acknowledged that, because it was a very small pool of relevant individuals for interview, it would not be possible to offer anonymity. Interviewees were aware of this when they agreed to the interview. In another case study, (UK, the Alcohol Health Alliance) individuals were promised anonymity but it was clear that the organisation would be named. In some case studies, authors sent penultimate drafts to key informants who were given the opportunity to comment and check anonymised quotations from their interviews. It is very likely that in most cases important stakeholders were aware of the limits to anonymity that could be offered within this study and, in the interviews, they seemed to represent their institutional positions, formulating official rather than private, informal opinions. It could be assumed that sometimes, their hidden agenda or interests were not overtly expressed.

4. Results

4.1. Introduction

The findings from the case studies are grouped into 3 categories. First of all (4.2.) we report on the eight case studies examining stakeholder activity in three controversial drug treatment approaches: opioid substitution treatment, consumption rooms, and heroin assisted treatment. Then (4.3.) we report on four case studies that consider the role of stakeholders in alcohol policy shifts, paying particular attention to shifts between an individualist/ treatment focussed approach and a whole population/ public health approach. Finally (4.4) we look at four cross themes that run through the case studies: the role of evidence and stakeholder activity; professional stakeholders at implementation level; families and drug users as stakeholders; the role of external stakeholders in national policy. In this section, as well as drawing on all case studies, we bring in the WP2 sub-study on nurses as stakeholders, pilot work on researchers as stakeholders in gambling, and a policy briefing on families of alcohol and gambling dependent people.

4.2. Stakeholder activity in drug treatment

Eight case studies looked at stakeholder activity regarding different aspects of drug treatment: opioid substitution treatment (OST); the use of consumption rooms (for heroin users); and the use of heroin-assisted treatment (HAT). Responses to the use of illicit drugs regularly provoke considerable controversy and this policy area illustrates well how differing worldviews and interests vie for position within the policy arena. The three topics chosen for case studies were (and still are in many countries) highly controversial; they engage groups of stakeholders coming from very different ideological starting points, embedded in different professional and institutional contexts and having – often – competing interests. All three approaches are considered as 'harm reduction' approaches and, as such, can be compared with total abstinence approaches. However, it would be a mistake to think of stakeholders as falling into one or other category. While some stakeholders do adhere more to abstinence or to harm reduction approaches, many others are more eclectic in their approach and espouse more mixed intervention methods. Furthermore, stakeholder positions are not static; stakeholders may change or modify their ideological stance depending on a host of factors, for example, funding for service provision, the overall policy or political context or the influence of new evidence.

4.2.1. Stakeholders in opioid substitution treatment

OST has been a contested topic since the 1980's when, in many countries – including the countries participating in WP2 - the HIV/AIDS crisis prompted widespread consideration of the use of methadone as one of a number of harm reduction approaches to address the threat of HIV spreading through injecting drug use. It continues to be banned in some countries. Russia, for example, with a large number of HIV infected people, mainly injecting drug users, continues to ban opioid substitution treatment, symbolically stressing the distinction between a Western immoral invention and Russian determination to make addicts drug-free (Mydans, 2011, cited in Malinowska-Sempruch, 2014). Even among professionals who support OST, there is a history of debate and conflict about the role of prescribing between those stakeholders who advocate its use on a long-term maintenance basis and those who support its use for withdrawal and an abstinence-oriented treatment ideology. In the UK, Mold (2008) has provided an historical analysis of the long- standing territorial disputes between the

different professional groups as to who should be in control of addiction treatment. The case studies used Kingdon's theory as described in section 2 to explore the processes of policy change and stakeholder activity.

The analyses of the six case studies that considered stakeholder issues regarding OST policy, revealed both differences and similarities across the partner countries. The studies also demonstrated well how stakeholder status, power and policy salience were influenced by context and by policy itself and how stakeholders attempted to increase their policy salience and influence policy.

Key findings:

History and Context:

- In the six countries (Austria, Denmark, Finland, Italy, Poland and UK), there are important differences in the emergence and evolution of stakeholder groups and in the political, cultural, and economic circumstances, which both constrain stakeholder activity and open up opportunities for specific actors at particular points in time.
- New stakeholders or alliances between stakeholders have emerged in the different countries in response to the changing nature of the 'drugs problem' and particular crises, such as HIV infection, and due to changes within the wider political, economic and social contexts. Contextual changes and crises provide 'windows of opportunity' in which new stakeholders can negotiate a space for their policy ideas. A prime example of this is Poland, where the economic and political changes post 1989, which coincided with the HIV epidemic, provided a 'policy window' in which new international stakeholders such as the World Health Organisation (WHO), the United Nations Office on Drugs and Crime (UNODC) and later on the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) could influence and support a harm reduction agenda.
- The legal, institutional, and administrative setting for substitution treatment in each of the six countries is highly differentiated. This means that substitution treatment is managed in various ways, but also that stakeholders have different starting points for influencing shifts of agendas given the different administrative contexts.
- Apart from Poland, Finland and Italy, where OST was introduced later, the 1970s was the time when OST began to gain ground. Though acceptance of this form of treatment differed between countries, the administrative structure for managing substitution treatment was founded in this period in most countries. In all countries except Denmark substitution treatment has primarily been regarded as a matter of health and medical regulation.
- Common to all countries is that substitution treatment is managed locally or regionally, based on national guidelines and action plans. It is, however, noticeable that Austria and Poland have not developed the necessary administrative structures or pressures to ensure access to substitution treatment in all regions of the country.

Stakeholders:

- Austria and Poland do not have the same heterogeneity of stakeholders as Italy, Britain and Denmark.
- There were differences regarding which professional stakeholders were most powerful and influential in the different countries: psychiatrists were relatively powerful in all countries (in the Austrian study they were viewed as the "established owners of addiction" although general practitioners had become more prominent since the 1990s). By contrast, in Denmark, the responsibility for substitution treatment policy is administratively divided between the Ministry of Health (prescription medicine) and the Ministry of Social Affairs

(psychosocial treatment). However, there had been a recent shift towards medicalisation, placing doctors in a more influential position. In Denmark and Italy there are key differences between physicians and non-medical professionals (i.e. psychologists, educators, social workers) in their views on OST but considerable consensus within professional groups, whereas in Poland, there was no consensus on OST within professional groups.

- All case studies reported treatment providers as powerful stakeholders with high autonomy at the level of practice. At the same time, there were differences, and rivalries, between treatment organisations linked to ideological differences regarding the need to focus on abstinence or harm reduction approaches.
- The picture regarding drug users as stakeholders is mixed. In some countries, they play active, visible roles as stakeholders while in others, they seem to be invisible and have not been engaged in public debates regarding policy. In Italy, user advocacy organisations have almost disappeared, although they were quite active in the 1990s. In Austria, drug users themselves were never given a 'voice' within policy development, although their views have been put forward by other stakeholders. By contrast, for a long time, drug user organisations have played important roles in the development of policy in Britain, even though they have been silent in the recent debates on abstinence-based recovery policies. Also, in Denmark, there has been a well-established user movement for decades, which has gained more power by making alliances especially with leading physicians and NGOs furthering harm reduction to drug users.
- Politicians and political parties have played important roles in the development of both the political rhetoric surrounding the substitution treatment debate as well as the policy choices. While in some countries it is possible to place punitive turns within drug user treatment policy and advocates for abstinence oriented treatment in the conservative/liberal wing of the political spectrum—e.g., in Austria, Italy, and the UK—this is more complex in the rest of the case studies. Government departments and civil servants have also been important although sometimes they have remained as less visible stakeholders fronted by expert or specialist committees. In the case of the current British drug user treatment strategy based on recovery, civil servants played key roles in persuading against the adoption of a wholly abstinence-based strategy with time-limited prescriptions.
- The case studies indicated that in some countries, notably Poland and Italy, the Catholic Church has considerable influence in political debates. In both countries, the church has exercised a conservative influence in favour of an abstinence, drug-free approach.
- Research access to the pharmaceutical industry was limited in all case studies. In Austria a long, informative interview was obtained with a representative of the pharmaceutical industry and one interview was obtained in the UK, but in Poland, representatives of the pharmaceutical industry (Molteni) refused to be interviewed. However, the pharmaceutical industry is seen as a powerful stakeholder in all the countries studied. For example, the Italian case study shows how the pharmaceutical companies, Molteni (producing methadone) and Reckitt Benckiser (producing buprenorphine) have funded scientific conferences and meetings, which have resulted in an alliance between the industry and scientific societies that bring together professionals who work in public services.
- No representatives of international stakeholders (e.g. WHO, EMCDDA, or other international organisation) were interviewed. However, the role and influence of international stakeholders was mentioned by several stakeholders in each of the six case studies. In some cases, interviewees reported that international influence had resulted in policy changes; in other instances, there was resistance to international pressures; frequently, guidelines or other evidence produced by international organisations are used

by stakeholders to support their own positions and policy preferences. In Italy for example, although the WHO guidelines on harm reduction and substitution treatment were considered influential by key stakeholders and had sometimes been used to support their position, they did not have the power to replace local regulations and practices. This, in itself, indicates the complex relationships and variable power between international, national, and local stakeholder groups and is reflected in several of the case studies. The influence of North American stakeholders - recovery advocates, such as Bill White and Thomas McLellan — were also seen as being particularly strong in the UK.

Ideological stances and stakeholders: The treatment goal:

- Battles between abstinence and substitution treatment take different shapes in each of the different countries. In Poland, it is both an ideological battle and also economic rivalry regarding the acquisition of scarce resources; in Britain, it is a debate about how to define 'recovery'; in Austria, the debate revolves much more around what kind of medication to use in substitution treatment and to what extent the user should have a choice.
- The economic aspects of stakeholder dynamics were not explored in detail. However, it was clear that there was competition for funding and resources between groups. For example, in Poland today, substitution treatment covers about 15% of those in need of treatment, and therapeutic community-based treatment modalities still absorb the largest percentage of funds. This led several stakeholders in the Polish study to underline the economic aspects of this battle. Agreeing to substitution treatment, as a possible way of treating drug use(r)-related problems, was also a potential threat to the financial and funding situations of therapeutic communities. Similarly, in the UK, strengthening the 'recovery' (abstinence) goal potentially could change the balance between harm reduction services and abstinence based services with respect to funding. Constraints on resources and the austerity agenda also mean that publicly funded treatment services are affected which may lead to greater reliance on self-help and mutual aid stakeholders. In Italy, according to many informants, the lack of resources has recently led to an excessive use of OST at the expense of socio-educational treatment and actions for social reintegration.
- The differences in how abstinence and substitution treatment are debated and take form depend, among other things, on whether there are powerful and important stakeholders advocating for abstinence. The therapeutic community, for instance, plays a major role in both Poland and Italy where they are often inspired by religion. In Denmark, however, no powerful abstinence oriented stakeholders have been present in the past couple of decades. In all countries, the HIV/AIDS epidemic has had an impact on substitution treatment policy mainly by opening a 'window of opportunity' toward implementing substitution treatment, or widening this approach where it is already in place.

Stakeholder action: problem legitimisation

- In all cases, problematisation—whether in favour of or against substitution treatment—has entailed the employment by stakeholders of a raft of legitimisation techniques. Research- based evidence, experience, moral argumentation, the need for international collaboration and consensus, economic and social pressures, all feature in the case studies.
- The processes of problematisation and legitimisation are neither static nor uni-directional; in all cases, there has been a shifting problematisation and solution seeking process regarding the provision of substitution treatment.
- In particular, the production, dissemination and use of research evidence were used by all stakeholder groups in all countries. For example, substitution maintenance treatment gained popularity in Finland due to the influence of a growing body of international scientific evidence. Stakeholders played pivotal roles in determining what evidence was produced, what forms of evidence were used to frame policy debates, and how different

types of evidence/sources were balanced against one another. The case studies reveal instances of evidence being used in overtly political ways to support different positions in relation to substitution treatment over time. In Britain, for instance, the discourse surrounding the use of methadone maintenance changed dramatically from being viewed as a highly effective treatment to being seen as a 'failing treatment' by some stakeholders.

- International networks linking researchers to policy communities are important in the drugs field and featured in the case studies as an important influence on how drug use is shaped as a problem and what kinds of solutions are seen as relevant and acceptable. International networks (e.g. International Harm Reduction Association – now called Harm Reduction International) have been particularly powerful in relation to the development of harm reduction initiatives, including needle exchange and methadone maintenance.
- The role of expert committees, both at national and international levels, has been important in relation to defining the 'drugs problem' and legitimising different policy and practice options. In the UK, the appointment of an expert committee was a key tactic in tempering the debate surrounding the role of substitution treatment within the development of the new recovery oriented system. This committee was chaired by an internationally recognized expert in the drug user treatment field, and supported by an International Advisory Group. The majority of stakeholders viewed the work of this expert committee, and their final report, as an attempt to build professional consensus within the field based on clinical judgment and evidence-based provision.
- Across the case study countries, researchers have played significant roles in providing evidence on the efficacy of substitution treatment to such committees. However, the degree to which they have participated in the policy debates and in advocacy has varied within countries, between countries and over time. In Italy, scientists with backgrounds in pharmacology, epidemiology, clinical medicine, and neuroscience were considered to be influential by other stakeholders. Interestingly, the scientists themselves did not regard themselves as particularly influential.

The full results of these case studies, along with commentaries on each case study, are published in a special issue of the journal *Substance Use and Misuse*: Beccaria, Einstein and Thom (2014).

4.2.2. Stakeholders and consumption rooms in Denmark

Drug consumption rooms are also part of a harm reduction approach. They are professionally supervised healthcare facilities that are established to provide safer and more hygienic conditions for drug users to take drugs and reduce public order problems. The first legally sanctioned drug consumption room was set up in Switzerland in the mid-1980s and during the 1990s drug consumption rooms were set up in other Swiss cities, in the Netherlands and Germany. Other countries set up drug consumption rooms from 2000 and onwards, including Norway, Spain, Luxembourg, Australia, and Canada. In most cases, the establishment of drug consumption rooms has been contested. In Denmark, the location of the WP2 case study, debate on the topic revealed deep-seated ideological divisions. Although accepting harm reduction approaches, successive governments blocked the use of drug consumption facilities based on a combination of legal reasons (signatory to international regulatory agreements) and ideological reasons (to aspire to a drug free society). Drug consumption facilities were seen to be in opposition to the basic ideology of Danish drug policy; and harm reduction policy, including drug consumption facilities, could, "... lead to a direct contradiction of the core of the drug policy: to counteract all non-medical and non-scientific use of drugs" (Regeringen, 2003, 6, cited in Houborg and Frank, 2014). The failure to respond effectively to rising numbers of drug-related deaths, concern about the marginalisation of drug users, visible open drug scenes

and the perceived inadequacy of the drug treatment system produced an overflow of concerns that manifest themselves at local level. While policy discussion on the national level was mainly among politicians, the local level saw a much wider diversity of stakeholders. Here the stakeholders were local politicians and the local administration, as well as different groupings within civil society. In 2012, Denmark introduced drug consumption facilities and this case study examined the factors, including stakeholder activity, which led to policy change.

The theoretical framework for the case study is provided by Kingdon's work, suggesting that policy change follows alignment of the policy streams and the opening of policy 'windows'. It is augmented by Callon's concepts of 'framing' and 'overflowing' where certain aspects of reality, concerns and interests are defined as relevant for collective action while others are not. The case study views stakeholder activity against the background of a shift from 'government' to 'governance' in drug policy (Rhodes, 1996; Stoker, 1998). As such, it has relevance to other countries where there has been a process of de-centralisation, entailing, in theory at least, devolution of power as well as responsibility for policy formation and implementation. Such a shift should mean engagement of a wider group of stakeholders active at different levels from national to local, and greater diffusion of power and influence over policy and practice. However, especially in policy areas where there are issues of law enforcement, state authorities are likely to be strong (if largely 'invisible') stakeholders. There has been little direct examination of state authorities as stakeholders in the addictions. The Danish case study posed a number of questions regarding the role of state authorities in bringing about the conditions likely to result in a policy window and (in this case) lead to acceptance of drug consumption facilities. These questions were:

> What role does the authority of the state and its institutions play in the processes of aligning particular problematisations with particular programs of action? Does state authority play an important role in making policy or is it more a negotiated outcome of the interaction between diverse stakeholders?

In this instance, stakeholders included the national government and particularly the Minister of Health, politicians at the national and local levels, different kinds of experts, NGOs and different civil society associations.

Key Findings:

This case study highlighted the following main findings:

- It showed a **dynamic policy process of continual framing and overflowing** where excluded interest and concerns would lead to policy changes.
- Attempts at municipal (local) levels to develop local drug policy and establish drug consumption facilities were blocked by existing Danish laws (e.g. zero tolerance policies) and possible sanctions on municipalities / cities contravening the laws. In other words, **a hierarchy between national and local government manifested itself on the basis of the sovereign power of the state.**
- **When politically expedient national government could get around international influence.** National government was able to interpret international drug control policy in ways that limited international jurisdiction over Danish drug policy and allowed for consumption facilities, thus indicating the strength of national authority.
- Regarding stakeholder action: An unofficial drug consumption facility established by Copenhagen municipality and an NGO was an act of civil obedience which engaged three types of stakeholders: traditional NGOs (running shelters for groups such as homeless people, sex workers, providing low level social and health services); new NGOs combining drug policy reform activism with the development of innovative interventions; local residents who were against the set up of drug consumption facilities, at least if situated in

their community. **Acts of civil disobedience grew in number and an activist network was established to campaign for policy change**.

- However, legalising drug consumption facilities took the power to establish new facilities away from the NGOs on the grounds that, because drug use was illegal, an agreement between the Municipality and the police was required to define an area of non-enforcement. Thus, **despite the activist role played by the NGOs, centralised authority was asserted at the Municipal level.**
- With regard to questions of governance, the introduction of drug consumption facilities in Denmark cannot be understood in terms of a shift from government to governance. **State control over the legislative and government institutions played a decisive role in framing the policy**.

Main conclusion: The space for governance seems to be limited in a drug policy that is prohibitive, at least when it touches upon issues that concern law enforcement and the sovereign power of the state. Such limitation clearly affects stakeholder power and policy salience especially at levels other than the state.

Full results are published in Houborg and Frank, 2014.

4.2.3. Stakeholders and heroin-assisted treatment: a transnational knowledge network

The third controversial topic, heroin-assisted treatment (supervised injectable and inhalable heroin prescribing), has been developed over the past two decades and has been supported by trials in Switzerland, the Netherlands, Germany, Spain, the UK, Belgium and Canada. Despite evidence of effectiveness, heroin-assisted treatment has been politically controversial in all of the countries that have conducted trials. It has been described by Khan et al (2014: 200, cited in Duke, 2015) as "one of the most controversial practices in clinical medicine despite its documented effectiveness". The emergence of epistemic communities or knowledge societies have become increasingly important within drugs policy making at the European level (Elvins, 2003). The concept of epistemic communities is actor based, so attention is focused on the source of ideas and the development of supranational 'expert' networks in particular policy and practice domains. These epistemic communities aim to attain an authoritative voice in issue areas, generate 'multistakeholder dialogue' and build consensus – with resultant implications for policy and practice at national level. Drawing on Stone's concept of the 'knowledge network' (Stone, 2013), the WP2 case study looked at the development of a transnational network of scientific stakeholders around heroin-assisted treatment (HAT) and the ways in which the expertise and knowledge in this area has been constructed, exchanged, mobilized and transferred between key actors in the different countries. Such analysis is important for understanding which forms of knowledge and expertise are defined as legitimate and credible and become reinforced over time through the mobilisation and transfer of scientific results and practices between scientists. The research design combined documentary analyses and 11 interviews with key scientific stakeholders, including scientists involved in conducting the RCT research in the various countries, members of the Cochrane Drug and Alcohol Group and representatives from the EMCDDA.

Key Findings

- Stakeholder group: The majority of those involved in the network were **psychiatrists**. This knowledge network became a recognized site of authority over time.
- **Boundary work** (Gieryn, 1983; 1999): They engaged in different forms of boundary-work which included demarcating between different professions, between different forms of

knowledge/science and between the production of scientific knowledge and its consumption by non-scientists.

- Nature of the evidence: They produced a specific form of science within the network, characterised by the **medical model and the RCT design**, and excluded other knowledges which do not conform to this particular techno-scientific criteria.
- Exclusions: **qualitative work** on the **experiences of patients and their families** (experiential knowledge) and the effects of HAT on the wider society in terms of **crime reduction** and the impact on heroin markets have been neglected.
- Credibility and authority: They produced publications in **high impact medical journals**, communicated the results as 'objective truths' and did not engage in overt political advocacy. Science was viewed as 'neutral' with a clear boundary between the production of scientific knowledge and political decision-making.

Main conclusion: Science and scientists are only influential in policy terms if their scientific findings 'fit' with the wider political, economic and social contexts at particular junctures in time. Individually, many of the HAT scientists have had influence in their own country on the development and implementation of HAT, on drug policy more generally and in other countries through advisory posts and their work as knowledge brokers. Furthermore, their aggregate contribution can be seen through the Danish example where HAT was implemented without a trial in Denmark because the existing evidence base from the other countries was seen to be both robust and applicable.

Full results are reported in Duke, K. (2015).

4.3. Stakeholder activity in alcohol control and public health policy

Four case studies considered the role of stakeholders in influencing alcohol policy change. Three studies examined long-term trends and changes while one study investigated stakeholder coalition formation and strategy. There was an interesting contrast between policy trends in Poland, Italy and Austria and in stakeholders' roles in influencing policy change. In the face of rising consumption and associated harms, Poland shows a shift away from alcohol control and a public health vision with a quite remarkable degree of consensus between very different groups of stakeholders regarding the inevitability of the political/ policy changes. Italy, by comparison, with falling consumption and a drop in related harm from the beginning of the 21st century, shows a shift towards greater controls on consumption and a move away from the focus on the individual towards a focus on public health. Policy in Austria has remained fairly stable following a major change in the mid 20th century when a raft of legislation established greater control over some aspects of alcohol-related harm (e.g. drink-driving) but placed emphasis on individual responsibility through establishment of a strong treatment system. Drink driving, although the subject of regulation, also placed emphasis on individual responsibility and included driver education/ improvement programmes as part of the response. In the UK, long-standing attempts to introduce a more public health based approach into alcohol policy began to bear some fruit and control measures associated with a public health view (such as use of price, restricted advertising, control over access and availability) emerged in public and policy debates. An important aspect of this trend was (is) the growth of more prominent and more influential public health advocacy groups. This is more noticeable in the UK than in the other partner countries. The fourth case study (see below) looks at one such group and describes the strategies it used to establish itself as a legitimate, credible, policy salient group.

Poland: This case study traced fundamental changes that took place in Polish alcohol policy at the turn of the 1980's. The changes consisted in rapid dismantling of a comprehensive alcohol policy whose foundations were laid in a highly centralised system of alcohol control supplemented by demand reduction measures including treatment; this was replaced by a new alcohol policy based mostly on school education and elaborated alcohol treatment. This new policy made alcohol cheaper and more accessible with a concomitant rise in alcohol consumption (including consumption of illicit alcohol) and a rise in alcohol-related morbidity, mortality and other harms despite substantial investment in, and expansion of, treatment.

Stakeholders interviewed for this study comprised public health researchers (4), policymakers and politicians (4), treatment professionals (1), AA and abstainers clubs (3), alcohol producers (3), consumers' organisations (1). They all shared similar beliefs in the inevitability of fundamental change towards privatisation and a free market economy. With the exception of researchers from the public health field, there was also a shared belief that alcohol control measures do not work any longer and neglect those who really need help. Thus, major stakeholders from the field of alcohol policy shared deep ideological as well as policy beliefs that rejection of the alcohol policy model that had existed under the socialist regime was inevitable and supported moves towards a quick transition to a market economy. Stakeholders associated with the previous administration disappeared or maintained their positions under new ideological banners. New stakeholders emerged and sought power and influence. A new office of Plenipotentiary for Solving Alcohol Problems was established at the Minister of Health and within a few years had become a State Agency for Solving Alcohol Problems (PARPA) - an important actor in the policy field. This fundamental shift from policy based on control measures to policy focused on education and treatment also required revision of the existing treatment paradigm. The new treatment paradigm, based on treatment and organisation models from the USA, eventually resulted in de-medicalisation of alcohol treatment – seen by some as "the psychologists protest, some kind of counter-action or retaliation" which reversed the previous power relationship between medical and non-medical professions. De-medicalisation also meant that the influence of the pharmaceutical industry was reduced. Education grew in importance bringing in teachers as important stakeholders at the implementation level.

Key findings:

- Turbulent political change was the context for major shifts in alcohol policy and in the dominant stakeholder groups in the alcohol policy field.
- There was a move away from state control of alcohol towards a free market approach.
- A process of de-medicalisation of alcohol treatment meant that medical professionals and the pharmaceutical industry became less powerful while non-medical professionals (e.g. psychologists) and educationalists gained more powerful positions in the policy arena.

Main conclusion:

At a time of fundamental, turbulent social change in Poland, a coalition emerged which included almost all stakeholders in alcohol policy. For all of them rejection of the previous alcohol policy model seemed to be inevitable, without any rational considerations of its advantages and/or disadvantages. All shared policy core belief that alcohol control measures such as limiting its physical availability and economic affordability are good for nothing in a new bright, liberal society where decent citizens are able to make rational choices. Adoption of AA and 12 steps ideology, which located the roots of a problem within an individual rather than in external determinants, supported and legitimised abrupt policy change. Finally, implementation of a model of treatment invented in the USA legitimised its introduction and

contributed to adopting policies that were rooted in a sense of the superiority of American science and its social organisation.

A full account is available in: Moskalewicz and Welbel (conference paper, 2015).

Italy:
Concern about alcohol is a very recent phenomenon in Italy, when, contrary to the situation in Poland (and in some other European countries), consumption and alcohol-related mortality had been falling since the 1970s. This case study focussed on the role of stakeholders in problematising alcohol consumption and influencing the formation and implementation of alcohol policy and on which stakeholders, in particular, took 'ownership' of the problem. Political interest arose in parallel with a number of changes in the conceptualization of the problem; among professionals, the concept of alcoholism changed to include acute intoxication as well as addiction; media coverage drew attention to single occasion excessive drinking and associated problems; and the growth of public guidelines on low-risk alcohol consumption increased the number of people considered to be 'at-risk' drinkers. The first framework law on alcohol was approved in 2001, after a lengthy parliamentary process. Analyses of the 10 Bills (1996-97) which preceded the law, reveal large numbers of amendments, and the conflicting views recurring in the texts indicate that they were not the result of a shared vision, even with regard to the (re)definition of the problem. The sponsor of the law – the MP Rocco Caccavari (a physician) – was the first and most active supporter of the process towards initiating the law. He had previously worked in the local addiction services, so that his election to parliament was an opportunity for health workers to affirm their turf rights. Fourteen interviews were conducted with: university professors (2), alcoholic beverages producers (2), politicians (2), public servant in Health Ministry (1), representative of scientific society (1), professionals in addiction/alcohol treatment units (4), self-help groups/voluntary associations (2).

Key findings:

A) Stakeholders:

- Having a 'champion' (Rocco Caccavari) within the legislature was an important facilitator.
- External stakeholders: Proposed solutions attempted to legitimize the problem and the solution by referring to the stances taken by international organizations such as the EU and WHO. The best strategy was seen to derive from total consumption theory.
- Local authorities were interested in extending their purview and increasing regional budgets, as well as public workplaces
- The National Alcohol Board, chaired by the Ministry of Social Solidarity and made up of the director of the National Health Institute (ISS), the President of the Italian Society of Alcohology (SIA) and numerous members was important in building respectability and developing constituencies.
- The Club of Alcoholics in Treatment, and professionals working with alcoholics in Local Addiction Services were the most active groups in supporting the law. They did so by establishing a strong alliance, even though they had differing visions of the problem and how to solve it. The world of voluntary associations played an important part in lobbying for the law's approval. Here, the Clubs of Alcoholics in Treatment (CATs) made a major contribution, more than other minor associations and Alcoholic Anonymous (AA), whose bylaws do not allow them to engage in political activity. According to some observers, CATs provided the "*greatest boost*" to the process (INT6_SER), acting as the "*yeast*" that raised the issue in politicians' eyes. With the support of the Catholic University in Rome and of the Ministry of Health, they adopted and promoted a prohibitionist approach.

- Producers also had an indirect role through the Minister of Agriculture, which defended their interests.

B) Role of evidence in the construction of alcohol as a problem:

- It was not the extent of the harm that explained why alcohol consumption came to be seen as a problem. Legitimisation of the problem was pursued less through data than through rhetoric, which often borrowed the arguments from the mass media and assumed a moral tone.
- Supporting data to frame alcohol as a problem were selected in order to find causal relationships to explain alcohol problems and their solutions.
- Foreign scientific research had a bigger role than Italian research in legitimising the problem, especially as regards the evidence incorporated in official international documents

Main conclusion. The study showed that a shared vision is not as essential as 'combining for strength' in order to create a public arena around a social problem when all subjects involved can gain something from the process or at least not lose out. Furthermore, not even scientific data are essential for demonstrating a problem, as the use of rhetoric seems to be more effective in building ideologies

A full account is available in Beccaria and Rolando (2014).

Austria:

The Austrian case study examined alcohol policy in the post World War II era. The main political parties in Austria – the socialists, the peoples party (formerly Christian social party) and the liberals (the former German nationalists) - traditionally represent different stakeholders and different ideologies – also in regard to alcohol policy: Traditionally the socialists represented the employees – the alcohol consumers, including problem drinkers as well as abstainers -, the conservatives small and rural enterprises - the wine growers, the beer and the spirit industry - and the Liberals the heavy industry – the employers. The political battles of the three parties also found expression in alcohol policy positions and prevented any change in alcohol regulations for more than 80 years. After World War II, a rise in alcohol consumption was accompanied by legislative measures to control alcohol-related harm (e.g. the introduction of a BAC level) and to establish a specialist alcohol treatment system. The increase of state interests in alcohol controls was also underlined by the establishment of an 'advisory board on alcohol questions' at the Ministry of Social Affairs which was also responsible for Health Affairs. The task of the board was to advise the Minister of Social Affairs and it had the competence to launch projects such as anti drinking campaigns and to draft proposals for legal regulations. These steps constituted a major policy change in Austria. Tolerance towards intoxication and few state regulations and interventions – the situation during the 19th and the first half of the 20th century - were replaced by stricter attitudes expressed through a larger number of regulations and interventions.

Key findings:

- The major shift in alcohol policy took place shortly after WWII in a context of party political consensus – partly enforced by the economic – political situation of the country (it was occupied and dependent on economic support), partly created by politicians who finally tried to overcome basic conflicts which had culminated in a civil war during the 1930s.
- The alcohol policy change of the 1950s was a compromise between controversial alcohol political positions which had prevented any major change for about 80 years.

- The alcohol policy change corresponded to Austrian attitudes towards drinking and intoxication as well as to general societal changes towards individualisation.

Main conclusion: The adaption of alcohol policy regulations to address contemporary problems was only possible when a party political consensus was instigated by external and internal forces.

UK:
The fourth alcohol case study looked specifically at the emergence and early development of a public health coalition, the Alcohol Health Alliance (AHA). A quite lengthy process whereby a group of less visible stakeholders helped to initiate the emergence of the new organisation preceded the formal launch of the AHA. These invisible stakeholders included individuals and other organisations and networks. Launched in 2007, the AHA aimed to re-frame awareness of alcohol consumption and related harms, to gain greater policy saliency for health compared to criminal justice priorities, and to shift policy towards adopting a population approach as compared to a targeted approach to intervention. The Alliance included medical bodies, charities and alcohol health campaigners, growing from an initial membership of 24 organizations to 34 member organizations by October 2013 (when the study was conducted) and rising to over 40 members by 2015. Nine members of AHA were interviewed for the study. They comprised one policymaker, three medical doctors and five non-medical professionals from member organisations.

Key findings:

- The learning accrued through the experience of setting up other health interest groups (e.g. around smoking) was available to individuals working to establish the AHA. This transfer of knowledge and skills between health alliances and groups is important in building stakeholder networks and constituencies which may enhance both access to policy makers and longer-term influence.
- Restricting AHA membership to organisations with a specific interest in alcohol and health facilitated consensus. This helped to consolidate core policy beliefs around preferred policy options.
- Despite general consensus, there were differences of opinion between members. In particular, these centred around contact and relationships with the alcohol industry with some AHA members believing there should be no contact between public health proponents and industry and other members taking a less extreme view.
- The Alliance drew on international sources of evidence to legitimate a population approach with a focus on regulation of advertising, price and availability of alcohol.
- A ‘charismatic leader’ figure was identified. The influential professional position of this individual and his links within important networks was useful in gaining legitimacy and credibility for the Alliance.
- The Alliance was supported (including the provision of some resources) by the Royal College of Physicians, an influential professional body with good policy and media links.
- Action was taken to reframe the alcohol problem as a public health issue through dissemination of evidence, strengthening the media presence of the Alliance and seeking to improve contact with sympathetic, influential politicians.
- The Alliance had some short-term success in contributing to an increase in policy attention to the possibility of new forms of alcohol price regulation (a move to minimum unit pricing).

Main conclusion: The formation of the AHA has demonstrated the role of advocacy coalition to contribute to re-framing policy and public discourse; but it remains to be seen whether such an alliance can maintain its initial impetus in opposition to more firmly entrenched policy beliefs and approaches supported by competing powerful industry interests and maintained through long established relationships and consultation processes.

A full account is available in Thom et al. (2015).

4.4. Themes explored across case studies

This section picks up a number of themes running through the case studies already discussed and brings in two new case studies – pilot work on researchers as stakeholders in gambling addiction and the WP2 sub-study on nurses. The first part (4.4.1) addresses the important theme of the role of evidence and looks in particular at the 'expert' and at 'scientific evidence' (and hence researchers) as stakeholders; data from the OST case studies and from the pilot work on researchers in gambling addiction are reported. Throughout the case studies, different groups of professionals and practitioners have been introduced and the case studies have provided some insight into their interaction within the policy process. However, the case studies reported so far did not explore stakeholder views at the local or 'grass-roots' level and did not examine in any detail one specific group of professionals. Section 4.4.2. gives the findings from the sub-study which surveyed nurses in emergency departments. The next theme (4.4.3) picks up issues around 'invisible stakeholders' or, as Ackerman and Eden (2011) term it 'crowd' and 'subjects'. We look at two groups: families of alcohol and gambling dependent people and drug users. The latter group provides an example of how stakeholder groups can shift their position to become more policy salient. Finally, in 4.4.4, we consider the wider context and how stakeholders external to the state can influence national policy and practice; in particular we highlight the role of international organisations as external stakeholders. It should be stressed that these themes emerged in the course of working on the project. They do not cover all the topics comprehensively but they do provide considerable insight into stakeholder dynamics and a basis for further research.

4.4.1. The role of evidence and stakeholder activity

A key theme emerging from the WP2 case studies is how stakeholders both use and produce knowledge and evidence. When looking at alcohol and drug policy governance, key questions include what counts as 'expertise', 'who counts as an expert and why', 'what counts as evidence' and 'who decides what counts'? While this theme ran throughout all the case studies, we explored the theme in more depth in an analysis of the role of evidence and the expert in the 'recovery' debate in England. Drawing on the theoretical insights offered by Backstrand's (2004) 'civic science' framework, the changing role of evidence and the position of experts in the processes of drugs policy governance were explored. The case study investigating the role of evidence and research in policy regarding the adoption of HAT (described above), clearly demonstrated that researchers could be a powerful stakeholder group in the processes of production and dissemination of evidence. As with other stakeholder groups, researchers are linked to professional networks, embedded in organisational structures and cultures, may also have advocacy roles and may have important positions in national and international organisations. We aimed to complement investigation of the HAT researcher knowledge network described above by looking at the role and influence of researchers in the gambling field. Specifically, we were interested in whether there were linked researcher groups across countries and whether they might be active as a knowledge

network. The main findings from these two studies are given below.

A further case study is on-going regarding epistemic networks in relation to heroin assisted treatment. The study is conducted by letting a web crawler retrieve articles written about heroin-assisted treatment from the Web of Science. On this basis, network analyses are conducted showing: a) how articles are connected through references, and b) how authors are connected through articles. In this way it has been possible to identify different 'clusters' of articles and networks of authors. Preliminary results show a number of the clusters and networks are national and/or related to language. Analyses and measures (including betweenness centrality) are also included in order to show the importance of different articles and authors on the basis of their position in the networks. This includes authors and articles that may not have many citations, but where the citations link up different clusters or communities.

See: Houborg, E. (forthcoming) A co-author network analysis of research on heroin assisted treatment *Drugs and Alcohol Today*.

Evidence and the expert: the case of OST in England

In England, the rhetoric of evidence-based policy and practice became generally accepted across policy spheres from around 1997 when the Labour government came to power. Within a rational knowledge-driven model of the relationship between policy and evidence, 'scientific' evidence was offered as the appropriate foundation for legitimising policy options at all levels. Scientific evidence was held to derive from particular forms of research with randomised controlled trials (RCTs), meta-analyses, systematic reviews, epidemiological analyses and 'modelling' studies being valued above research adopting what was seen as less rigorous methodologies. In this model, the 'expert', as interpreter (and sometimes the producer) of evidence is at the forefront. At the same time, a process of de-centralisation of policy with concomitant establishment of new networks and administrative structures was taking place (a shift from government to governmentality) bringing in a range of local stakeholders with increasing responsibility for local policy and decision-making. As a result, an increasing number of stakeholders have become involved in policy debates and governance networks and have drawn on evidence to argue their case. At the same time, the notion of a particular type of policy relevant evidence has been under criticism. There has been the call for a broader notion of knowledge-based policy and practice, which includes the experiential knowledge of practitioners and the lived experiences of service users. These trends challenge the notion of the 'expert' and 'scientist' as the authoritative voice in the research-policy interface. Recent debates between stakeholders surrounding the role of 'recovery' in drugs treatment, particularly regarding the place of OST policy was used as a window into examining both the nature and role of evidence and the role of 'experts' in influencing policy. The following main findings emerged.

Key findings:

- The established place of methadone maintenance as an evidenced, effective treatment for drug addiction and (according to some views) the legitimation for the government to expand bureaucracy for drug treatment policy, was challenged by: re-interpretation of the existing research to focus on exit from treatment rather than treatment per se: the more prominent entry into the policy debates of stakeholders supporting abstinent approaches: quantitative survey research with clients of treatment services reporting that clients wanted an abstinence goal and the use of this research as 'ammunition' by some stakeholders: role of the media in the construction of a 'methadone problem': a powerful

imagery of drug users 'parked on methadone' was used by stakeholder groups to advocate for abstinence based services.

- The recovery debate was influenced by external factors: notably, the Betty Ford Institute Consensus Panel (USA) and individuals such as Professors Thomas McLellan and William White (USA) who were recovery advocates and regarded as international experts. Developments in Scotland, adopting a broader definition of recovery based on mental health, were also influential.
- The appointment of an expert group, led by a prominent psychiatrist, was set up to develop a clinical consensus and appropriate clinical protocols for OST. The group included stakeholders from a wide range of different professional backgrounds chosen carefully to ensure that a broad range of perspectives was represented. However, the degree of 'real' participation by some members was questioned and some saw the group as representing the 'old world order' i.e. dominated by 'doctors' and organised by the National Treatment Agency. An international advisory group, including a member from the Cochrane Drugs and Alcohol Group, a key researcher from Australia, and 3 recovery advocates from the United States, supported the expert group.
- Despite inclusion of practitioner and experiential perspectives, the adherence to the hierarchy of evidence (i.e. the dominance of RCT studies) is apparent in the brief given to the expert group by the National Treatment Agency and in their subsequent review of the evidence.

Main conclusion: The use of 'scientific' evidence was of paramount importance to the conclusions of the Expert Group's report, as was the endorsement of the international network of experts. In part, this was due to the brief given to the Group – which emphasises the influence of those who establish national advisory or expert groups over the inclusion or exclusion of bodies of evidence and illustrates how parameters are set which tend to perpetuate the types of evidence and science which are given legitimacy and credibility in policy and practice debates. Fundamentally, it demonstrates, as in other WP2 case studies, that representation and participation do not necessarily lead to democratisation of science. The case study highlights the close relationship between what is perceived and accepted as policy relevant evidence and how that form of evidence becomes firmly embedded within dominant policy structures and systems. As an integral part of established systems, supported by powerful stakeholders, the evidence itself becomes the basis for attracting resources and extending the evidence base, thus making it less likely that challenges will be successful.

A full account is available in: Duke K. and Thom B. (2014)

Gambling research networks: Is there an international knowledge community? A pilot study

A recent Alice Rap policy briefing[1] (Bühringer et al., 2013) documented gambling–related problems and noted the need for effective action in Europe. It also recorded the scarcity of adequate and appropriate evidence for policy formation, stating:

> "While there is an increasing body of research on member state level, the lack of EU policy-relevant and informative studies is a major obstacle and further research in this field is essential. The most urgently required topics for further research are comparable epidemiological studies, as well as effectiveness trials for prevention and treatment options."

According to the policy briefing, there are currently discussions in academic spheres and consensus building activities in scientific groups aiming to bring together the scarce scientific

[1] http://www.alicerap.eu/resources/documents/doc_download/128-policy-paper-2-gambling-two-sides-of-the-same-coin.html

evidence and draw insights from substance use research. There is, therefore, a clear role for researchers as stakeholders to become engaged and contribute to policy on gambling.

This pilot work aimed to assess the extent to which researchers were engaged in cross-national collaborative work and whether they were likely to constitute a 'knowledge network' with potential influence on policy on gambling.

Methods:
In order to map the emergence and expansion of publications on gambling as an addiction, two key journals were sampled for the purposes of comparison, one originating in Europe – *Addiction* (UK based), the other in Canada - *Journal of Gambling Issues***.** All issues were searched – 1990 to present day for *Addiction* and 1999 (since its inception) to present day for *Journal of Gambling Issues*. Searches were carried out in February 2014. The abstracts of both journals were searched using the terms: 'gambling addiction', 'excessive gambling', 'pathological gambling', 'compulsive gambling', 'problem gambling'. Abstracts were read to ensure relevance and validity.

Of 269 hits for *Addiction* 113 were valid; while 121 hits produced 114 valid results for *Journal of Gambling Issues*. The authors, institutions and country of the first author for each valid publication were noted to identify and map the key stakeholders. Author references were not always found to be consistent, either between the two journals or simply in the amount of detail given for a particular author and their institution. Sometimes an Addiction Centre was mentioned as an affiliation, at other times it was omitted.

Researchers identified by the journal search were approached with a request to complete a short survey. The survey aimed to gather information on researchers' perceptions of the influence of national and international research on policy. From 41 survey requests sent out by email, only 11 replies were received after three follow up attempts. Most replies were from Finland (4), with 2 from the Netherlands and 2 from the UK; and Norway, Switzerland and Ireland (1 each). This aspect of the work has not yet been developed any further.

Key findings:

Growth of publications on gambling as an addiction

- Despite the shorter publishing time period for JGI (a difference of 9 years) a similar number of papers where gambling is considered as an addiction has been published over the time period searched – 113 for Addiction and 114 for JGI
- Gambling as an addiction began to evolve at the turn of the millennium with each journal experiencing different peaks in growth of publications; the general trend has been upwards with 12-14 relevant articles in peak years (2009-2013).
- Profiles of both journals differ according to the country of the first author's institution. English speaking countries such as Canada, USA, Australia and UK are the largest contributors to both journals; however, USA, Australia / New Zealand and UK have more publications in Addiction while almost half of all the publications in JGI are from Canada. To some extent this reflects both journals' origins – *Addiction* is UK based while *JGI* originated in Canada.
- In Europe, the Nordic countries are better represented in JGI while Addiction attracts authors from the Netherlands in particular.
- International collaboration on publications is demonstrated for both journals, but especially in *Addiction*. For example, one collaboration involved institutions from Canada, Israel, Brazil and USA (*Addiction*, 2012); another involved 14 authors from USA, Germany,

Netherlands, China, Singapore, Mexico, France, Spain and Australia (*Addiction*, 2014). Australia, Canada and USA are often partners in international collaborations.

Institutional output

- The following European countries are represented in the outputs: France; Germany; Netherlands; Italy; Nordic countries (Denmark, Finland, Norway, Sweden and Iceland); Spain, UK (England and Scotland).
- Looking at Europe, France, Netherlands, Denmark, Norway, Sweden, England and Scotland have institutions with the highest numbers of first author publications within the two journals. Authors within institutions from the other countries listed above (Germany, Italy, Finland, Iceland, Spain) have fewer papers published in which they are first author, usually only one paper. The focus in the following points is on countries where institutions were identified with greater outputs.
  - In **France** 3 institutions, each of them universities, have publications in these journals. The University of Nantes has the largest publication output with 6 authors contributing to Addiction and JGI. A specific gambling addiction centre is located there. Gaëlle Bouju and Marie Grall-Bronnec are first authors on 2 papers.
  - The largest publication output in Addiction and JGI in **the Netherlands** is from the University of Amsterdam which houses an addiction research institute. Of the 8 authors publishing within the university, 3 are first authors on papers. Anna E. Goudrian is a key figure at the Amsterdam Institute for Addiction Research.
  - In **Denmark**, Aarhus University has 7 authors and Jakob Linnet is a significant author.
  - The University of Bergen has the highest number of authors identified as contributors from **Norway**. 8 authors have publications in Addiction journal. Both Geir Scott Brunborg and Stale Pallesen are first authors on papers.
  - The main institution contributing to the journals in **Sweden** is Stockholm University with all papers coming from the Centre for Social Research on Alcohol and Drugs. 2 authors are located there; Per Binde at Goteborg University is also a key author.
  - In **England,** the University of Birmingham has the most significant output in the two journals. There are two authors working at an addiction research centre there, one of whom is Jim Orford, a key researcher in the field; he is first author on 9 publications. There is also a leading author at Nottingham Trent University which houses a gambling research unit; Mark Griffiths has contributed to 4 publications in the two journals and is first author on 3 of them. Kenny R. Coventry works at the University of Plymouth where 3 authors are identified in the two journals.
  - In **Scotland,** Glasgow Caledonian University is the main institution with papers in either JGI or Addiction. There are two authors publishing papers working at the university. Crawford Moodie is a key author based there. He is also linked with researchers at University of Stirling.
- Outputs from institutions in other countries were: Canada- 31 institutions, some with gambling research centres; USA – 40 institutions; Australia – 20 institutions; New Zealand – 2 institutions; 9 countries in Asia, Central and South America.

A knowledge network of research scientists

- A considerable number of institutions fostering gambling research and hosting specialist gambling addiction units were identified in Europe as well as in Canada, USA and Australia. Examination of relevant publications indicated collaborative efforts between scientists within and between countries.
- Unlike research scientists involved in HAT we found no indication of focussed, co-ordinated researcher activity (beyond publishing) within the international community although there are some national and European efforts to link researchers and provide

policy relevant research/ information:

- In the UK, there is the website Gambling Watch UK (http://www.gamblingwatchuk.org). Prof. Jim Orford, a prominent UK researcher in this field, is well linked with researchers in other universities in the UK, Europe and Australia, and provides advice to government and campaign groups such as the the Farer Gambling Campaign which has been very effective in raising the issue of the harm associated with the high stake Fixed Odds Betting Terminals to be found in betting shops.
- The European Association for the Study of Gambling "provides a forum for the systematic study, discussion and dissemination of knowledge about all matters relating to the study of gambling in Europe" (http://www.easg.org/website/general_info.cfm?id=70). Its membership comprises gambling organisations/ industry as well as research and treatment organisations. This mixed membership is a possible source of tension (as in the alcohol field) and a reason why some research scientists will not attend EASG conferences.
- It is useful to note the conclusions from Cassidy et al. (2013) regarding gambling research which provide some support for our own tentative findings

  :The field of gambling studies is closed and tightly controlled. It is shaped by relationships with the industry and the state as well as within the academic establishment. Relationships between researchers, treatment providers and industry are often unmediated by formal academic structures.

  :Conferences are dominated by industry interests and do not encourage critical debate. The industry is adept at discrediting research, leading some researchers to self-censor or opt out of publishing.

  :Competition for limited funding has created a research culture that is suspicious, sometimes hostile and even paranoid. This creates inefficiencies including unproductive rivalries and duplication. It makes it difficult to retain good researchers and to attract new recruits to the field.

  :Gambling research can create reputational risks for institutions. Senior management are not always supportive of colleagues working in this area. Entering and remaining in the field of gambling studies is therefore a considerable challenge, especially for early and mid-career researchers.

  :Gambling journals are not highly rated and the peer review process is conservative.

  :Gambling studies is not a prestigious field when viewed from other disciplines including anthropology, sociology, law, geography and economics. It is behind studies of tobacco, alcohol and drugs in terms of analysis, methods used, ethical transparency and dealing with conflicts of interest.

  :There is a lack of collaboration between gambling studies and related fields and a reluctance to accept alternative methodologies and wider definitions of evidence. The impact of creating disciplinary bunkers is that internally homogeneous communities of referees and commentators participate in self-referential dialogues, rather than engaging in wider, more creative discussions.

Main conclusion: This pilot study demonstrated a rise in the number of publications on problem gambling and in the number of institutions involved in gambling research from the late 1990s, indicating increasing involvement of the research community in this policy area. Individual researchers appear to be active in promoting evidence based advocacy approaches to informing policy but do not appear to have formed an international knowledge community. In Ackerman and Eden's (2011) terms, this group of researchers may have potential power but may lack interest in policy engagement; alternatively, they may be interested but lack sufficient power to open windows of opportunity or to take advantage of windows when one

arises. Additionally, Cassidy et al's (2013) study, depicts both internal and external pressures on the research community which act as a barrier to developing a broad based international knowledge community. These comments derive from a very preliminary research exercise and further research is needed to clarify existing and potential stakeholder roles.

A draft paper with details of the journal search is available from B. Thom.

4.4.2. Professional stakeholders at implementation level

Feasibility of alcohol screening in emergency departments: a case study among nurses: Above summaries of WP2 case studies illustrate the diverse range of professional groups active in the addictions field. While medical professionals – in particular psychiatrists, physicians and general practitioners - have been prominent in most partner countries, the extent to which they have 'owned' the field has fluctuated and changed over time, between countries, and between substances / addictions. There are also differences between professionals who are part of policy networks and communities at national level, often involved in research as well as clinical work, and professionals working at implementation levels. Apart from the Danish study of consumption rooms described above, which considered municipal and local level issues, most WP2 case studies focused on stakeholder dynamics at the national level.

By contrast, the Finnish sub-study offers insight into the attitudes and responses of nurses working at local level in the 'front line' in primary and special health care clinics. Forty-two nurses working in the primary health care clinics and 38 in the specialised clinics completed a questionnaire designed to find out about their professional practices and attitudes and assess the feasibility of alcohol-screening interventions in these outpatient clinics. As policy in many countries has shifted towards a public health approach, identification and early intervention with 'at risk' drinkers has attracted increasing attention as an important component of a population approach. Identification and brief advice (IBA) or similar approaches have been applied not only in clinical but increasingly in non-clinical settings and expectations of professional involvement in delivering IBA have broadened beyond doctors, the original target group for delivery, to include nurses, pharmacists, social workers, educationalist and youth workers etc. The expansion of IBA illustrates how a treatment/ intervention approach can bring in a new range of stakeholders, although, as much of the literature indicates, stakeholders who are frequently 'reluctant' stakeholders in that they are not particularly willing to become engaged (Thom et al. 2014).

Although there were differences between the two groups of Finnish nurses, overall, they reported that they were not implementing alcohol screening methods like AUDIT-C-test regularly even though they reported encountering intoxicated patients quite often, particularly in the special health care clinics. Nurses in special health care were more pessimistic about the usefulness of asking about patients´ drinking than nurses in primary health care. Their reasons were similar to those given in other studies (lack of time, perceived low motivation of the patient, frustration about the low success rate, patients' attitudes and institutional barriers). The findings suggested that there is a need for solutions and arrangements at the institutional level to support nurses in their work as well as giving them greater power to influence not only the conditions of their work, but also broader alcohol policy processes. The results of the Finnish study raise issues of stakeholder resistance and possibly boundary protection of professional roles, which need to be addressed to move forward in prevention of alcohol-related harm.

Boundary work, as we have noted in other case studies, is a professional strategy that is

commonly adopted by stakeholders striving to increase their professional position and policy influence and/ or protect their existing position. It warrants further examination across professional groups and across national contexts. Understanding how and why boundary work is carried out may have practical implications for how policy makers, service commissioners and other authorities attempt to innovate or spread new interventions.

An account of the study is available in Warpenius, Holmila and Heikkilä (2014).

Medical professionals: Drawing on the drug substitution case studies, a further cross-national analysis of professional groups has been undertaken. This analysis examines the changing roles of medical professionals as stakeholder in policy processes and in treatment practices in Danish and British substance use treatment. Despite somewhat similar approaches to substitution treatment, the two countries have developed rather differently within the past decades. We investigate how and why the role of medical professionals as stakeholders have developed so differently, and we examine the kinds of evidence used to promote specific stakeholder´s perspectives in these processes. Findings show how, despite similar starting points in the 1960´s/1970s, when both Danish and British substitution treatment services were based on oral methadone and some form of psychosocial treatment to respond to increasing numbers of young heroin users, the development of drug treatment and the roles that medical stakeholders occupy have been shaped by country-specific trajectories and contexts. That is, different ways of defining, conceptualizing and problematizing drug use and treatment have led to the development of different kinds of spaces for medical professionals as stakeholders in particular substitution treatment policies and practices. The Danish case illustrates the impact of re-conceptualizing the drugs problem from social terms to medical terms and the resultant implications for stakeholder groups, particularly medical professionals. In contrast, the British case highlights the dominance of medical conceptualisations of the drugs problem historically and the various attempts at re-defining it through a wider social problematization in the early 1980s, as well as the inherent tensions with the criminal justice system which have persisted over time.

An account of the study will be available in Bjerge, B., Frank, V.A. and Duke, K. (forthcoming) Medicalization or de-medicalization? A comparative analysis of medical professionals as stakeholders in policy processes and in treatment practices in Denmark and UK *Drugs and Alcohol Today*

4.4.3. 'Crowd' and 'subjects': Families and drug users as stakeholders

Ackerman and Eden's (2011) power/ interest matrix draws attention to individuals who are affected by policy but are not interested in becoming involved as active stakeholders or lack the power to do so. As 'crowd' or 'subjects' they lack power, and in the case of 'crowd' interest as well. There is a tendency to think of such 'invisible' stakeholder groups as composed of the most socially vulnerable. However, as we noted above in the Finnish nurses' case study, there may be reluctance among some groups to accept the role of active stakeholder and resistance to any attempts at engagement. Moreover, as the case studies have demonstrated, powerful stakeholders, notably civil servants and other prestigious individuals and groups may be very active and involved behind the scenes but practically invisible (and often un-researched) in policy analyses.

Families of alcohol and gambling dependent people are, by and large, invisible as stakeholders in the addictions field. While they are sometimes linked into self-help organisations, they are generally not politically organised and lack a unified voice. Indeed, many of the self-help

organisations (largely based on 12 step approaches) that support families, deliberately refrain from any political action. This group, which could be categorised as 'crowd', is the subject of a WP2 policy briefing. However, it should be noted that there are examples of parents and relatives of drug users becoming organised; in the Italian example mentioned below, parents became a very visible group advocating against ham reduction (OST) approaches.

Drug users, on the other hand, provide a good example of how a vulnerable group of 'subjects' were able to attain 'player' status even if to a moderate degree in Denmark and the UK whereas in Austria they remained as 'crowd' or 'subjects' and in Italy they experienced a loss in power and dropped from 'player' status. We look at these two groups in turn.

Adult and child family members affected by their relatives' excessive alcohol use or gambling: This policy briefing was based on the international literature but with a focus on the UK. It presents the arguments in three parts. Part one summarises the stressors experienced by adult affected family members (AFMs) of close relatives with alcohol or gambling problems, the coping dilemmas they face, their needs for information and support, and their heightened risks for ill-health. The second part does the same, but specifically for children and young people who are affected by living with parents or carers with alcohol or gambling problems. Some of the difficulties in the way of routinely providing help for affected family members, whether children or adults, are considered in the third part.

Key findings:

- Adult AFMs constitute a group which is at high risk of ill-health. A consistent finding is that AFMs obtain high mean scores on standard measures of general ill-health and show increased odds of having a clinical level of psychiatric disorder, especially depression. AFMs bear personal and household or family-wide 'costs', often substantial, of living with addiction. Some of those costs would otherwise be borne by governments.
- Child AFMs experience many of the same stresses, dilemmas and strains as do adult AFMs as well as additional emotional and psychiatric difficulties related, for instance, to the caring roles they often adopt. They often suffer other problems, such as conflict situations and violence, chronic parental mental or physical ill-health, parental criminality, social disadvantage and instability.
- In the UK, there is comparatively little policy focus specifically around parental alcohol misuse and its impact on families. The situation with regard to gambling is even worse. It is even unclear which government departments should take the lead with these issues.
- There is little in the way of coordinated national or European gambling policies and nothing much of note regarding the impact of gambling problems on AFMs.
- Social work services focusing on child care is one principal location for the identification of harmful effects of adult alcohol problems on children. However, social workers are still insufficiently trained around substance misuse issues and the social work profession has been almost silent on the issue of problem gambling.
- There remains a need for a greater understanding of how services can engage child and adult AFMs who may be in need of help but who are not currently known to services. Policy should not take a narrow focus only on family members of relatives who are the most dependent drinkers or heaviest gamblers.
- Scarcely any intervention methods for AFMs in their own right have been thoroughly researched and none has been adopted routinely or even widely.
- Informal support for AFMs is often lacking or perceived as unhelpful; even in countries with comparatively well developed services, professionals are often perceived by AFMs as lacking in knowledge, awareness or even sympathetic understanding.

A fuller discussion is available in Orford (2015).

User groups as stakeholders: Drug user groups are a relatively new category of stakeholder in the addictions. As such, they give voice to the populations most affected by addictions policy. They are also an example of how a less visible group, with little policy legitimacy, credibility or policy salience can, in certain circumstances, increase their influence within the policy arena. In 2005, there were drug user groups in 14 European countries, including Denmark and the UK. Many user groups are part of INPUD (International Network for People who Use Drugs), set up in 2006, and other European and international networks. These international networks have become increasingly prominent through their lobbying activities and participation in policy conferences and debates. For example, they have been influential players in the development of harm reduction initiatives, and the INPUD is invited annually to speak and participate in the high level sessions of the Commission for Narcotic Drugs at the United Nations office in Vienna.

This WP2 study is based largely on cross-national analysis of the data collected in the OST studies described above. It uses Backstrand´s (2003; 2004) concepts of participation, representation, and democratization, and aimed to demonstrate *how* and *why* the level of user participation, representation as well as involvement in democratization processes varies from country to country. For many stakeholders, representation is a matter of both the abilities and possibilities to engage in collective action; thus, to investigate the influence of user groups as stakeholders it is valuable to take into account the opportunities and constraints to engaging in collective action, which will vary with the political and administrative structures of different societies.

Key findings:

- The UK and Denmark have active drug user stakeholder groups; in Denmark there have been elaborate attempts to include user perspectives in policy processes, yet these attempts can be described as inconsistent. In the UK drug users are represented and participate in policy making structures through user involvement initiatives at national and local levels. Participation and representation of drug users in policy is weaker in Italy and practically non-existent in Austria. Whereas there are some indications of a possible strengthening of drug user influence in Italy, this is not visible in Austria.
- Overall, the study illustrates that the countries represented are only beginning to grapple with the issues of representation, participation and democratization, apart from Austria where the process of involving drugs users as experts in policy development has not even begun. Even within countries such as the UK and Denmark, where these processes have been developed the most, there are limited 'windows' for drug user participation to emerge and fully develop.
- **Moving to 'player' status**: The main factors which appear to have facilitated drug user's moving to a position of 'player' include broad developments such as: the HIV crisis of the 1980s, the establishment of larger international networks which engaged in lobbying activities; and national contexts such as the opportunities to engage in collective action and inclusive approaches such as consultation and representation on committees which give drug users a 'voice'. Some main factors which facilitated or impeded drug user groups' emergence as 'players' are illustrated from the 4 country accounts.
  - **UK**: a multidisciplinary approach to the drugs problem; formation of active drug user groups at local level; drug user activism became linked to issues (and groups) around e.g. human rights, drug law reform, empowerment and patient rights; establishment of a

National Treatment Agency with user representation on the board and in service planning and delivery at local level.

- These developments linked drug users as 'players' into the established national structures and channels of communication and provided a parallel hierarchy of linked local to national activist groups specifically advocating for drug users.
- This helped to facilitate acceptance of experiential knowledge as a legitimate form of evidence and ensured its incorporation into policy discussion.
- **Denmark**: active engagement was mainly undertaken by one Copenhagen group, Danish Drug Users Union (DDU); represented on the Narcotics Council Board (Ministry of Social Affairs); political divisions over the Board's recommendations for harm reduction measures and Board closed down with change of government; the DDU lost representation on the new, broader based Board.
- The possibilities of drug users participating in Danish policy processes on a national level can best be defined as rather unstable depending on shifting governmental priorities.
- However, drug users are represented in other ways: through alliances with related organisations e.g. the Street Lawyer; occasional invitation to DDU to comment on proposed national policy.
- Although, compared to the UK, drug user groups in Denmark are less closely integrated into official structures and less dispersed and organised across the country, the DDU has become a legitimate voice and recognized as a relevant stakeholder to consult in policy matters related to drug issues.
- **Italy**: While the UK and Denmark provide useful examples of factors that facilitated the emergence and strengthening of drug user stakeholders, it is instructive to look at the barriers that have impeded such development in Italy.
- In all countries, activism tended to emerge around the delivery of harm reduction approaches, but in Italy, the influence of the Catholic Church, which supported abstinence, led to an attitude of moral condemnation towards users that inhibited consumers' action and was by exploited right-wing politicians, therapeutic communities (abstinence based), and highly visible parents and relatives groups. Although an informal movement appeared during the 1990s, it did not succeed in influencing policy.
- Recent developments signal the possible opening of a new 'window of opportunity' for users to gain a more influential position in the policy arena. This arises from: the activation of cannabis consumers, who are not subject to the same stigma that plagued heroin addicts: and the use of the web to reach, inform and involve more consumers / supporters around the issue of rights.
- **Austria**: The early medicalisation of drug users and thereby the role of drug users as patients may have silenced the potential desire as well as the limited attempts of users to organise themselves.
- Major barriers have been: traditional inequalities between different forms of knowledge (experts vs. non-experts); these are re-produced without any form of challenge regarding drug related issues.

A full account is available in Bjerge et al. (in press).

4.4.4. The role of external stakeholders in national policy

While WP2 case studies focussed mainly on national level analysis, we were constantly reminded that national policy and practice is influenced in many different ways by events and stakeholders external to the partner countries. Quite apart from international agreements and formal collaboration between governments (e.g. within the EU), which have both clearly visible and more subtle influences at the national level, there are many collaborative efforts between

researchers, scientists, practitioners and other stakeholder groups, and there are global economic and political interests which have an impact on policy at national level.

This case study is a cross-national analysis of data gathered for the studies on OST. It draws on data from Poland, Italy, Denmark and Austria. National drug policies are particularly sensitive to external pressure, as they must operate within the scopes imposed by the United Nations (UN) conventions. The implementation of these conventions is carefully monitored not only by the UN agencies but also by individual countries such as the United States, which not only contributes the lion's share to the UN budget but has own global drug policy interests as well. Other stakeholders include the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA), Open Society Foundation, Global Drug Policy Commission, or Harm Reduction International (HRI). In this case study, we look at examples of how external influences that include external frameworks and stakeholders affect national policies; in particular how they are referred to in epistemic work to construct what the world around drugs is about, and what is proper, evidence-based and desirable policy and practice in this area.

The findings need to be understood against the different historical and contemporary differences between the countries. Experiences from the four European countries, representing different regions, various welfare traditions, as well as different drug epidemiology, show that national drug policies are not autonomous actions taken by sovereign nations, but are strongly dependent on external influences, in particular, the UN agencies. The UN drug conventions, which claim to preserve universal moral order, are imposed and monitored by super-powers, the USA being the most important guardian of the conventions. It is notable that there is no total consensus between international agencies regarding the direction of drug policy with organisations such as WHO and UN AIDS advocating more liberal approaches. At a different level, while the USA is also a major 'exporter' of policy and practice 'models', the country accounts show that better off European countries also offer their policy models and often employ epistemic work (offering training, conference attendance, advisory assistance etc.) to encourage colleagues in other countries to adopt their policy and treatment formats.

Key findings:

Austria: has a long history of coming under pressure to conform with international regulations; the USA – the leading stakeholder and proponent of strict drug controls – seemed to have played the main prompter role; Austrian politicians and authorities were in a powerless position and the changes in the national drug policy documents were substantial. However, despite the resultant stricter controls and the debates following international pressures, external influences did not stop or even interrupt the process of medicalisation of drug related problems and the normalisation of treatment initiated decades ago. In both recent and earlier decades, the "Austrian way" was successfully defended against external influences.

Denmark: The UN bodies and conventions played important roles in developing Danish drug policy; they provided the rationale for the rejection of safe injecting sites until 2012. As with Austria, introduction of more restrictive drug policies in 2004 was inspired by USA policy and its rhetoric of the 'war on drugs'. Despite external pressures, the harm reduction movement has influenced the development of Danish treatment and social care systems towards implementing harm reduction approaches to help drug users. Links between Danish professionals and international movements such as the International Harm Reduction Association (IHRA) (now Harm Reduction International) may have had some influence. International influences can also be seen in the adoption of drug monitoring systems and

monitoring tools and quality assurance techniques drawing on research from the USA and the UK. As found in the Danish study of consumption rooms, Danish domestic stakeholders used the authority of external influences both to resist policy change and to introduce it when convenient. In a way, external stakeholders did not impose their solutions to the problem but were carefully selected by domestic stakeholders to support their particular interests or opinions.

Italy: After World War II the international community, and in particular the United Nations, played a major role in directing the Italian governments' policies on drugs. For instance, the first Italian Consolidation Act about drugs (L. 1041/1954) was prompted during the UN 1950 and 1953 Narcotic Drugs Committees meetings, by French and Canadian representatives complaining about Italian slowness in the prosecution and trials of drug traffickers. Successive shifts between more liberal and more restrictive drug policies ran parallel with changes in government and in national politics; during Berlusconi's terms of office (2001-5, 2008-11), the approach to drug problems was closer to USA than European approaches. From the start, the Department for Anti-drug Policies (DPA) activities were oriented towards building alliances and prestige at the international level, i.e. at the USA level. Indeed the Board of the Department– today inactive – included, in that period, more than 70 members. Importantly, its scientific committee had 11 members including 6 from the USA and 1 from the UK and members came from a narrow range of disciplinary backgrounds with a focus on neuroscience. The government in this case had clearly operated an ideological and political choice in that the Committee had an emphasis on biomedical science, particularly neurosciences, and excluded Italian scientists (including neuroscientists) and especially those from social research applying an interdisciplinary approach.

Poland: As alcohol is the favourite drug in Poland and other psychoactive substances are alien to Polish culture, the appearance of illicit drugs in Poland, their perception and social response have almost always been strongly influenced by external influences. During the period of transition to a market economy, external stakeholders became very active (e.g.WHO, UN AIDS, Soros). For instance, cooperation between Polish and foreign NGOs provided the first disposable needles and syringes and bilateral cooperation between Polish and British health authorities exposed Polish professionals to the experiences of UK practitioners of responding to HIV infection which hit such cities as Edinburgh several years earlier. A WHO/EURO training programme was also influential in introducing Polish practitioners to harm reduction methods. As in other countries, political forces and political change interacted with external influences from international organisations and from specific countries; this initially helped to introduce harm reduction measures, including opioid substitution treatment, but eventually gave way to legitimizing the introduction of new drug legislation and policies which gave priority to repressive measures at the expense of harm reduction and methadone maintenance.

A full account is available in Beccaria et al. (in press).

5. Conclusions

5.1 The stakeholder concept

In the introduction, we noted the importance of considering construct equivalence in undertaking cross-national research. The 'stakeholder' concept was of particular importance as it was the central unit of analysis for this WP. Despite some reservations, the concept proved to be useful, possibly because the WP2 team were all social scientists and because the English term has been adopted in social science discussions in most of the partner countries. It was noted (and this is reflected in some of the language differences) that the term 'interest group' (also common across the partner countries) conveys a conflict model of stakeholder action whereas the term 'stakeholder' – possibly because it stems from the business/ organisational field – indicates a more consensual model of action where there is an interest in bringing different stakeholders together. In the addictions field, there are examples of different groups with different interests building alliances around common goals (e.g. the case study on the Alcohol Health Alliance) and there are examples of attempts to build consensus and collaboration at national and European levels, especially in alcohol (e.g. the European Alcohol Health Forum and the UK Responsibility Deal). But there were clearly many examples of conflicting interests (e.g. alcohol industry and public health advocates) even within the health and treatment fields (e.g. abstinence –based, therapeutic community providers and harm reduction providers). Consensus and conflict models of action, therefore, both provide useful, appropriate perspectives on stakeholder dynamics. Finally, although the term 'stakeholder' risks becoming meaningless if a broad definition is adopted (as in this WP), taking a broad view of stakeholders allows us to include groups who may at one time be powerless or lack the interest to become actively engaged but who, with changing circumstances, may shift from a 'crowd' or 'subject' status to 'player' status; the broad definition encourages examination of stakeholder dynamics and change over time.

5.2 Theoretical frameworks

The study of stakeholder dynamics, in its contemporary form, as it has changed over time, and as it is manifest in different countries is too complex to be adequately supported by the use of one theoretical perspective. The case studies reported in this document combined a number of theoretical frameworks to investigate different aspects of stakeholding (detailed in section 2). Kingdon's work provided a basic framework which informed all the case studies and which proved applicable and relevant across partner countries and across substances. In particular, the concept of 'policy window' (the point of juncture of the three policy 'streams') was a useful heuristic device for investigating the plethora of factors which stimulate shifts and changes in stakeholder groups at a particular point in time. The importance of the 'window of opportunity' was underlined in case studies (e.g. trends in alcohol policy and stakeholding in Austria and Poland) where, in the one case, political stability was an important factor in preventing change for a considerable period and where, in the other case, rapid political and economic change opened up opportunities for shifts in stakeholder ideologies and influence. Kingdon's theory was, of course, not sufficient to explain many of the processes and outcomes of stakeholder activity. Ackerman and Eden's power/interest matrix was helpful in considering the relative power of different stakeholder groups and in viewing stakeholder power/ interest as a continuum where the combination of the two dimensions could change over time and for many reasons, resulting in changes in stakeholder policy salience. Advocacy coalition theory

was used to look in more depth at the importance of belief systems in forming alliances and coalitions and in helping to build consensus within and between stakeholder groups. Justification theory provided insights into the process of decision making, showing how stakeholders rationalise and justify their perspectives and actions especially within policy disputes. Theories on 'framing' helped to reveal how shifts take place in thinking about an issue, in defining it as policy relevant and in persuading others to accept a new or altered conceptualisation. It also highlighted the need to pay attention to excluded interests and concerns as a potential challenge to the status quo. 'Boundary' work, too, was an important concept in understanding how professionals and groups draw protective boundaries around their professional roles and around their knowledge base in order to exclude stakeholders who threaten their position in the policy arena or in order to strengthen their own position. Epistemic community theories and knowledge network theories informed the examination of stakeholder groups which crossed national boundaries and drew attention to the complex power relationships between international activity and national policy.

By combining a range of theoretical perspectives across the case studies, WP2 partners were able to take into consideration the wider political, social, economic and cultural contexts of stakeholder action, the opportunities and 'windows' for representation and engagement, the belief systems which underpinned stakeholder action and the dynamics of stakeholder action across time.

5.3 Conducting cross-national stakeholder analyses

Beyers et al. (2008: 1104) have argued cogently that "understanding interest group systems remains crucial to understanding the functioning of advanced democracies, especially in an era when these democracies are becoming increasingly embedded in supranational policy networks". This WP is significant in that it considered stakeholder roles and dynamics across several European countries, at different levels from international to national to local and across substances and addictive behaviours. The research has produced new insights into some of the similarities and differences in stakeholder involvement in the addictions in some European countries. Inevitably, there are limitations and gaps in what we have produced. In particular, in the course of conducting the research we were aware of the many theoretical and methodological challenges which arise in conducting cross-national research. For instance, we could say that the study as a whole used pluralistic research approaches which incorporates different epistemologies, theoretical traditions and practices with associated analysis techniques spanning a range of theoretical and empirical frameworks (Frost et al., 2010). Data collection and analyses of the main case study data were undertaken by each partner team separately leading to possible differences in analytical approaches which could affect interpretation and understanding of the data. Working across country case studies to produce the cross-national analyses for the themes discussed in section 4.4, raised issues such as how to fit the findings from some countries into a common theoretical frame and whether there were differing interpretations of the same findings. These are important considerations which, in the time available, could not be explored in detail. It is also easy to highlight gaps in what we have done – more attention could have been paid to the different levels of stakeholder action; further work is needed to explore the relationship between international (European) stakeholder networks and their influence on national policy; additional cross country/ cross substance thematic analyses are possible using the data already collected. There are, therefore, plenty of opportunities for further investigation opened up by this study.

Finally, while there are distinct differences in the political structures and systems of WP2 partner countries, they are all advanced western political systems, relatively open to

representation and participation by a range of stakeholder groups. Our findings are, therefore, not necessarily relevant to countries with very different political systems or with very restricted opportunities for political/ policy participation.

5.4 Key findings

Earlier sections have documented the richness of the findings from the case studies and they have provided ample illustration of the contribution of stakeholder analyses to understanding policy processes and policy outcomes in the addictions field. The following highlight main insights and provide useful pointers for future research.

- Contextual (e.g. political, social and economic) changes and crises provide 'windows of opportunity' in which new/ some stakeholders can increase their policy salience, re-frame understanding of the issue and negotiate a space for their policy ideas. Equally, such changes can result in a loss of policy salience and influence for other stakeholder groups.
- In mapping out stakeholder groups, it is useful to consider 'invisible' (or 'crowd') stakeholders. These are not only vulnerable groups (such as users/ addicted people and their families) but may include powerful groups such as civil servants, local authorities or professional institutions active behind the scenes.
- While medical professionals (psychiatrists and in some cases general practitioners) have tended to be the dominant 'owners' of addiction, their dominance depends in part on the prevailing beliefs regarding the nature of the problem and its solution and their links with the national and local administrative structures which allocate responsibilities and resources. Shifts have occurred in some countries over time in the dominance of different professionals within the medical profession and, specifically, the dominance of psychiatry.
- Stakeholders' involvement in processes of legitimation (and de-legitimation) are key to establishing their position (and policy salience) in the policy arena. These legitimation processes include: legitimating their view of the problem, their view of the solution, and their own position in relation to other stakeholder groups.
- It is difficult for new stakeholder groups or new alliances to disrupt and compete with stakeholder groups which have long-standing, entrenched relationships within the policy arena and with policy decision makers. Shifts in political systems can open a 'window of opportunity' for such groups.
- In framing the problem area, stakeholders exclude concerns and interests - aspects of 'reality' - which do not fit their conceptual framework. 'Boundary work' can be discerned regarding professional roles, stakeholder group composition and roles, and in demarcating 'scientific' evidence from other forms of evidence. Some scientists, for example, see their work in producing science as separate to its consumption, drawing boundaries between 'science' and other forms of knowledge and between the production of 'science' and involvement in policy.
- Science and scientists are only influential in policy terms if their scientific findings 'fit' with the wider political, economic and social contexts at particular junctures in time.
- The inclusion or exclusion of bodies of evidence in policy decision making is generally determined by which types of evidence (and which experts) are given legitimacy and credibility. What is perceived and accepted as policy relevant evidence tends to become an integral part of established systems, supported by powerful stakeholders; the evidence itself becomes the basis for attracting resources and extending the evidence base, thus making it less likely that challenges will be successful. Representation and participation of stakeholder groups (e.g. on government committees) does not necessarily lead to the democratisation of science.

- Representation in the policy arena is a matter of both the abilities and possibilities to engage in collective action; thus, to investigate the influence of specific social groups as stakeholders it is valuable to take into account the opportunities and constraints to engaging in collective action, which will vary with the political and administrative structures of different societies.
- Consensus building and alliance formation are major strategies which can gain greater policy salience for stakeholder groups. Multi-stakeholder dialogue is an important feature of knowledge networks/ epistemic communities but does not always have influence on national policy outcomes.
- A shared vision of a problem or response is not as essential as 'combining for strength' in order to create a public arena around a social problem where all subjects involved can gain something from the process or at least not lose out. Furthermore, not even scientific data are essential for demonstrating a problem, as the use of rhetoric may be more effective, in some cases, in building ideologies.
- International organisations (WHO, UN, EU, EMCDDA etc.) are recognised as important and influential stakeholders. While these organisations can pressure national governments to implement specific policies, national governments can (do) use international edicts to support their policies when convenient and also find ways of resisting or re-interpreting international regulations to suit national needs and preferences.
- The space for governance seems to be limited in a drug policy that is prohibitive, at least when it touches upon issues that concern law enforcement and the sovereign power of the state. Such limitation clearly affects stakeholder power and policy salience especially at levels other than the state.
- Considerable tensions exist in both the alcohol and drug policy/ practice fields which may not always be in the interests of 'best practice'.

5.5 Towards a framework for cross-national analyses of stakeholding in the addictions

Following from the view proposed by Brugha and Varasovsky (2000: 240) cited earlier, that stakeholder analysis: "focusses on the interrelations of groups and organisations and their impact on policy, within a broader political, economic and cultural context", the WP2 project findings indicate the importance of five key dimensions of stakeholding for the development of a framework for cross-national analyses of stakeholding:

- A context specific account of stakeholder position and activity – describing changes over time, using a 'thick' description of the political, economic, social and cultural contexts which frame 'problem' definition, responses to the issue, and stakeholder action.
- Mapping the full range of stakeholders relevant to the issue to include groups that are visible and actively engaged and those that are less prominent or 'invisible' (lacking in power, lacking in interest, invisible for other reasons – e.g. civil servants).
- Consideration of levels of stakeholding: international (epistemic community and knowledge network activity), national level, regional, and municipal/ local. Attention to the degree to which there is administrative devolution and de-centralisation (a governance approach) and the effect of administrative structures on stakeholder composition, power and interaction; in particular consideration of stakeholder roles in the multiple institutional arenas, how they interact at European level and how EU and international level policies can impact of national opportunity structures.
- Examination of internal and external factors which may impact on stakeholder groups' legitimacy, policy salience and positioning at any particular time. What counts as internal

and external factors requires definition; e.g. it will depend on the level of stakeholding being considered. (External may be international organisations, donor organisations, epistemic community action etc. impacting on national policy; or national level policy/ regulations impacting on devolved governments/ municipal and local level policy decisions. Internal may be the degree of conflict of interest or of alliance between stakeholder groups and may be related to wider factors such as competition for resources).

- Understanding of stakeholder strategies and tactics to legitimise the group and the group's view of the problem, and to gain/ retain/ increase policy salience and influence for the stakeholder group. Important strategies are likely to be: production and use of evidence, gaining access to the media and forming relationships with influential institutions/ authorities, building relationships with relevant decision makers, attempts to de-legitimise opposing views/ stakeholders/ policy options.

6. References

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